

54599

ARH1.0001227355

ARHIP54599

Mrs. G ANANDAMMA | Female | 93Yr 0Mth 1Days

LOWER RESPIRATORY TRACT INFECTION
COMMUNITY ACQUIRED PNEUMONIAf566

C/o shortness of breath, fever with dry cough since 2 days associated with generalized weakness

Known case of hypertension, hypothyroidism and regular medication

AT ADMISSION:

Afebrile

PR: 90/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 80%

P/A: Soft,

A 93 years old female patient Mrs. G ANANDAMMA came with c/o shortness of breath, fever with dry cough since 2 days associated with generalized weakness. Known case of hypertension, hypothyroidism and regular medication. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION, COMMUNITY ACQUIRED PNEUMONIA. Managed conservatively. Cardiologist, pulmonologist consultations taken and advice followed. Patient attendant requested for discharge, patient referred to higher center for further management.

54590

ARH1.0001227339

Name	Mr. R SATYANARAYANA
Patient Identifier	ARHIP54590
Age	58Yr 0Mth 1Days
Sex	Male
Date of Admission	02-Feb-2022
Date of Discharge	
MLC No	
Address	JYOTHINAGAR ,Karimnagar,Telangana
Ward/ Bed No	First Floor, Day Care, Bed no:DC 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWMI

MILD LV DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (02/02/2022) -CAD-DVD (LAD,LCX) left dominant system

PLAN PTCA+DES TO LAD

MEDICAL MANAGEMENT FOR PDA

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 58 years old male patient Mr. R SATYANARAYANA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, MILD LV DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (02/02/2022) -CAD-DVD (LAD,LCX) left dominant system, PLAN PTCA+DES TO LAD, MEDICAL MANAGEMENT FOR PDA. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001226585

Name Mrs. AFZAL
BHI

Patient Identifier ARHIP54386

Age 64Yr
0Mth
21Days

Sex Female

Date of Admission 19-Jan-2022

Date of Discharge

MLC No

Address PEDDAPALLI,Other,Telanga
na

Ward/Bed No First
Floor,
CT
POST,
Bed
no:CT
2

Primary Consultant Dr SOMASHEKAR K

SURGERY -CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, D1, PDA]
DONE ON 29/01/2022.

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION
+ DM+HTN+S/P AWM

C/o chest pain a/w SOB since 3 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 64 years old female patient Mrs. AFZAL BHI presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION + DM+HTN+S/P AWTI, SURGERY -CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, D1, PDA] DONE ON 29/01/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, MILD TR/PAH , NO PE/CLOT/VEG

BMI is __ kg/m².

Sr. Creatinine report on 30.01.2022 __ mg/dl.

DISCHARGE MEDICATION:

-
- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
 - 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
 - 3) TAB. STROLIT 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 4) TAB. ND-LIT ONCE DAILY AT 8AM TO CONTINUE.
 - 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
 - 6) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.
 - 7) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
 - 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
 - 9) INJ HUMAN MIXTURED 10 Units TWICE DAILY AT 8AM AND 8PM CONTINUE

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

.0001226691	Name	Mr. KATKURI ASHOK	
	Patient Identifier	ARHIP54362	Age 34Yr 0Mth 17Days
	Sex	Male	Date of Admission 17-Jan-2022
	Date of Discharge	24-Jan-2022	
	MLC No		
	Address	1-137/1,MULKALLA,MANCHERIAL,Telangana	Ward/Bed No First Floor, SICU, Bed no:SICU 5
	Primary Consultant	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	Consultants
	Surgeons	DR. SUBRAT KUMAR SOREN -- NEUROSURGERY	Anesthesiologists Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

Diagnosis

Diagnosis

Disease	Disease Type
SEVERE HEAD INJURY RIGHT EDH,LEFT FRONTO TEMPORAL CONTUSION,DIFFUSE CEREBRAL EDEMA	Pd

ARHIP54362

ARH1.000122669



Surgery / Procedures
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
RT FTP CRANIOTOMY,EVACUATION OF EDH	17-Jan-2022 18:30:00			

C/O alleged to have sustained injury due to RTA 2 wheeler vs 4 wheeler at 1 PM on 17/01/2022, sustained injury to right shoulder

Patient has LOC, 1 episode seizure+

Right ear bleed +

PHYSICAL EXAMINATION:

ON ADMISSION

PR-65/min

BP-120/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-98%

GCS: E1,V1,M4

A 34 yrs old male patient Mr. KATKURI ASHOK came with alleged to have sustained injury due to RTA 2 wheeler vs 4 wheeler at 1 PM on 17/01/2022, sustained injury to right shoulder ,Patient has LOC, 1 episode seizure+, Right ear bleed +. All necessary investigations done and diagnosed as SEVERE HEAD INJURY RIGHT EDH,LEFT FRONTO TEMPORAL CONTUSION,DIFFUSE CEREBRAL EDEMA. Surgery: Right FTP DECOMPRESSIVE CRANIOTOMY,EVACUATION OF EDH done on 17-01-2022. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. LEVIPIL 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 2) TAB. PAN 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 7 DAYS TO NEUROSURGERY OPD

ARH1.0001226856

Name Mr. MOTKURI
BAGIAH

Patient Identifier

ARHIP54417

Age 44Yr 0Mth 9Days

Sex

Male

Date of Admission 21-Jan-2022

Expired Date

30-Jan-2022

MLC No

Address

katkur,Karimnagar,Telangan
a

Ward/Bed No First Floor, SICU,
Bed no:SICU 2

Primary Consultant

Dr. GOUTHAM ROY
(MS(General
Surgery),Consultant General
Surgeon)--GENERAL
SURGERY

Consultants

Surgeons

Dr. GOUTHAM ROY
(MS(General
Surgery),Consultant General
Surgeon)--GENERAL
SURGERY

Anesthesiologists Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY

Cause of Death

Cause of Death

Diagnosis

Diagnosis

Disease

Disease Type

ACUTE INTESTINAL PERFORATION WITH LONG SEGMENT GANGRENOUS BOWEL INVOLVING
JEJUNUM AND ILEUM

C/o pain abdomen since 3 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-99%

A 44 yrs old male patient came Mr. MOTKURI BAGAI AH came with c/o pain abdomen since 3 days. All necessary investigations done and diagnosed as ACUTE INTESTINAL PERFORATION WITH LONG SEGMENT GANGRENOUS BOWEL INVOLVING JEJUNUM AND ILEUM, SURGERY: EXPLORATORY LAPAROTOMY + PROXIMAL JEJUNAL RESECTION AND ANASTOMOSIS DONE ON 25/02/2022. Patient was on ventilator. On 30/01/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 01.36 PM on 30/01/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO ACUTE INTESTINAL PERFORATION WITH LONG SEGMENT GANGRENOUS BOWEL INVOLVING JEJUNUM AND ILEUM.

ARH1.0001227307

Name	Mr. MD MAHMOOD		
Patient Identifier	ARHIP54583	Age	44Yr 0Mth 3Days
Sex	Male	Date of Admission	01-Feb- 2022
Date of Discharge			
MLC No			
Address	JAGITYAL,Karimnagar,Telangana	Ward/Bed No	First Floor, RECOVERY ROOM, Bed no:RR 9
Primary Consultant	Dr. Vidya Sagar A--		

ATYPICAL CHEST PAIN

SR, NORMAL LV FUNCTION [EF-60%]

R/F : SMOKER

CORONARY ANGIOGRAM (04/02/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o SOB on exertion a/w profuse sweating

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 44 years old male patient Mr. MD MAHMOOD came with c/o SOB on exertion a/w profuse sweating. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV FUNCTION [EF-60%], R/F : SMOKER, CORONARY ANGIOGRAM (04/02/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 9PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001221644

Name Mr. SYED AHMED
HUSSAIN

Patient Identifier ARHIP52904

Age 50Yr
4Mth
16Days

Sex Male

Date of Admission 19-Sep-2021

Date of Discharge 21-Sep-2021
MLC No

Address POTKAPALLI,Karimnagar,Telanga
na

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU1
2

Primary Consultant Surgeons Dr. Vidya Sagar A--CARDIOLOGY

Consultants Anesthesiologists

☐ **Diagnosis**

Diagnosis

Disease	Disease Type
MITRAL VALVE PROLAPSE(PAPILLARY MUSCLE RUPTURE)SEVERE MR,SEVERE PAH,SR,NORMAL LV FUNCTION,ACUTE PULMONARY EDEMA,CKD,CVA(09/09/2021)R/F-DMT2,HTN,SEVERE ANEMIA,EF-62%.	

C/o severe shortness of breath grade- IV

K/C/O CAD with severe PAH, severe MR

CKD, type II diabetes mellitus, Hypertension and severe anaemia

AT ADMISSION:

Afebrile

PR: 109/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 50 years old male patient SYED AHMED HUSSAIN came with c/o severe shortness of breath grade- IV, K/C/O CAD with severe PAH, severe MR, CKD, type II diabetes mellitus, Hhypertension and severe anaemia. All necessary investigations were done and diagnosed as MITRAL VALVE PROLAPSE(PAPILLARY MUSCLE RUPTURE)SEVERE MR,SEVERE PAH,SR,NORMAL LV FUNCTION,ACUTE PULMONARY EDEMA,CKD,CVA(09/09/2021)R/F-DMT2,HTN,SEVERE ANEMIA,EF-62%.Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. RENOSAVE ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. SHELCA LONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. CUDCE FORT TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. RAMISTAR 1.25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001039144

Name	Mrs. K BHARATHA
Patient Identifier	ARHIP54614
Age	52Yr 9Mth 21Days
Sex	Female
Date of Admission	04-Feb- 2022
Date of Discharge	
MLC No	
Address	KODIMIAL,,Karimnagar,Andhra Pradesh
Ward/ Bed No	Ground Floor, Emergency Ward, Bed no:EME4
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY

CRHD, MILD MR/PAH

SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%]

R/F: HTN

CORONARY ANGIOGRAM (04/02/2022) - CAD- mild disease

ADV: MEDICAL MANAGEMENT

C/o chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old female patient BHARATHA came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CRHD, MILD MR/PAH, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], R/F: HTN, CORONARY ANGIOGRAM (04/02/2022) -CAD- mild disease, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. PROLOMET XL 25MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: RAMISTAR 2.5MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB: VELOZ 20MG ONCE DAILY AT 8AM BEFORE BREAKFAST TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001227313

Name	Mrs. ERRA LAXMI		
Patient Identifier	ARHIP54582	Age	66Yr 1Mth 3Days
Sex	Female	Date of Admission	01-Feb-2022
Date of Discharge			
MLC No			
Address	1-122/3, KHAIRAGAON KOMARAM BHEEM 9182827179 ,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 45%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (LAD)

PLAN CABG WITH GRAFT TO LAD.

C/o left sided chest pain sudden in nature a/w SOB

At Admission

Afebrile

PR: 86/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 66 years old female patient LAXMI came with c/o left sided chest pain sudden in nature a/w SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 45%, R/F: HTN, T2DM, CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (LAD), PLAN CABG WITH GRAFT TO LAD. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. TELLZY-H ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. BETALOC 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. TAB. GLYCOMET GP1 ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS/PLBS REPORTS

ARH1.0001225396

Name	Mrs. A RAJAMMA
Patient Identifier	ARHIP54411
Age	60Yr 1Mth 22Days
Sex	Female
Date of Admission	21-Jan-2022
Date of Discharge	
MLC No	
Address	JAGITAL,Karimnagar,Telangana
Ward/Bed No	First Floor, CT POST, Bed no:CT 5
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant- Cardio Thoracic & Vascular Surgeon)--C T

CHRONIC RHEUMATIC HEART DISEASE, MITRAL RESTENOSIS+SEVERE MS+SEVERE TR WITH PAH IN AF + DM+OBESITY+OLD PULMONARY KOCH'S

Surgery: MVR WITH SJ NO. 27 mm, MECHANICAL VALVE DONE ON 07/04/2022.

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old female patient Mrs. A RAJAMMA came with c/o SOB on exertion a/w palpitations since 7 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE, SEVERE MS+MR, Surgery: MVR WITH SJ NO. 27 mm, MECHANICAL VALVE DONE ON 31/01/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, NORMAL FUNCTIONING PROSTHETIC MV, NO VALVULAR/PARAVALVULAR LEAK, NO LV RWMA, MILD MR/TR/AR/PAH

BMI is 17.6 kg/m².

Sr. Creatinine report done on 01.02.2022 1.5 mg/dl

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 1MG ONCE DAILY AT 7PM TO CONTINUE LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. MET-XL 50 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 8AM FOR 11 DAYS
- 5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
- 6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS
- 9) TAB. DERIPHYLLIN R 150 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

ARH1.0001227204	Name		Mr. VEMULAWADA GOPAL
	Patient Identifier	ARHIP54544	Age
	Sex	Male	Date of Admission
	Expired Date	03-Feb-2022	

MLC No

AddressTADIJERI,GANGADHARA,Karimnagar,Telangana

Primary ConsultantDr. Vidya Sagar A--CARDIOLOGY

Surgeons

Ward/Bed No

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Add Diagnosis

Disease	Disease Type
CAD INFERIOR WALL MI MODERATE LV DYSFUNCTION EF35%.	

C/o chest pain since 3 days

AT ADMISSION:

PR: 89/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient Mr. VEMULAWADA GOPAL came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CAD INFERIOR WALL MI MODERATE LV DYSFUNCTION EF35%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.10 AM on 03/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CAD INFERIOR WALL MI MODERATE LV DYSFUNCTION EF35%.

54592

ARH1.0001227343

		Name	Mr. RAJAMALLU T	
Patient Identifier	ARHIP54592	Age	68Yr	
Sex	Male	Date of Admission	02-Feb	
Date of Discharge				
MLC No				
Address	SULTHANABAD,Karimnagar,Telangana		Ward/Bed No	First no:MR
Primary Consultant	DR. NIKHIL GOLI --			

CVA, SUBACUTE SDH

C/o altered sensorium since 2 days,
Drowsiness, Irrelevant talks since 15 days

K/C/O DM ON REGULAR MEDICATION

AT ADMISSION:

Patient - Drowsy

PR: 115/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 68 years old male patient Mr. RAJAMALLU came with c/o altered sensorium since 2 days, drowsiness, Irrelevant talks since 15 days. All necessary investigations were done and diagnosed as CVA SUBACUTE SDH. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) INJ. MANNITOL 100 ml TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) INJ. LEVIPIL 500 mg TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) INJ. PAN 40 mg ONCE DAILY AT 6AM FOR 5 DAYS
- 4) INJ. ZOFER 4 mg TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) INJ. OPTINUERON ONCE DAILY AT 8AM FOR 5 DAYS
- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. MODALERT ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.00012272 40	ARHIP545 59	Mr. DANDU BHUMAI AH Male 72Yr 1Mth 4Days	110 A	30-Jan- 2022	DR. SRI KARAN UDDESH
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SYMPTOMATIC HYPONATRAEMIA
COVID-19 MODERATE
HYPOKALAEMIA (RESOLVED)

C/o fever 10 days ago following which he was afebrile

H/o decreased appetite since 7 days

H/o loss of consciousness on 03/01/2022

K/C/O HTN, CAD, S/P PTCA (5 yrs ago)

AT ADMISSION:

Patient drowsy, not oriented

PR: 99/min

BP: 110/60mmHg on 8 ml/hr Noradrenaline

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100% on 4 Litrs O2

P/A: Soft

A 72-year-old male patient BHUMAI AH presented with the above-mentioned complaints initial sodium value was 102 mEq/L, patient was treated with 100 mL bolus of 3% NACL patient's sodium improved to 107 3% NACL infusion was continued over 3 days patient's sodium was corrected to 127/96 hours of hospitalisation patient was treated with INJ. Actacrez for secondary bacterial infection. Patient was treated with INJ. DEXA and INJ. REMDESIVIR for COVID-19 patient's GCS improved after sodium levels were on the rising trend. Patient initially had hypotension the patient was given INJ. NORADRENALINE. 2D echo was done which showed regional wall motion abnormality. CT chest was suggestive of cardiomegaly and CORADS 2. Now the patient is haemodynamically stable and is alert so the patient is being discharged

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN AV 75/20 ONCE AT 2PM FOR 7 DAYS
2. TAB. MET-XL 25 MG ONCE AT 2PM FOR 7 DAYS
3. TAB. PAN 40 MG ONCE AT 7AM BBF FOR 7 DAYS
4. SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM

REVIEW ON FRIDAY (11.02.2022) WITH Sr. ELECTROLYTES REPORT TO GENERAL MEDICINE OPD.

To decide on diuretics after Sr. Electrolytes

ARH1.0001227224

Name Mr. D
DEVAIAH

Patient Identifier ARHIP54555

Age 44Yr
0Mth
6Days

Sex Male

Date of Admission 30-Jan-2022

Date of Discharge
MLC No

Address BASNTHNAGAR,
PEDDAPALLY,Ramagundam,Telangan
a

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU2

Primary Consultant Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

CORONARY ANGIOGRAM (30/01/2022) -CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 30 MM RESOLUTE ONYX DONE ON
30/01/2022

PROBABLE RICKETTSIAL DISEASE

C/o left sided chest pain a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 44years old male patient Mr. D DEVAIAH came with c/o left sided chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMi, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], CORONARY ANGIOGRAM (30/01/2022) -CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.0 X 30 MM RESOLUTE ONYX DONE ON 30/01/2022, PROBABLE RICKETTSIAL DISEASE. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
- 5) TAB. DOXY 100 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
- 6) TAB. IVABRAD 5 MG ½ TAB TWICE DAILY AT 8AM 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012268 18	ARHIP545 91	Mr. M A RAHEEM Male 75Yr 0Mth 16Days	122 B	02-Feb- 2022	DR. SRI KARAN UDDESH
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URINARY TRACT INFECTION
 ATRIAL FIBRILLATION WITH CONTROLLED VENTRICULAR RATE

C/o fever with chills, generalized weakness since 2 days

H/o dysuria since 2 days

K/C/O HTN, DM
 Recent history of inguinal hernioplasty

AT ADMISSION:
 Febrile - 102 F
 PR: 144/min irregular
 BP: 130/80mmHg
 RS: BAE+
 CVS: S1S2
 RR: 18/min
 SPO2: 98% on room air
 P/A: Soft

A 75-year-old male patient Mr. M A RAHEEM presented with the above-mentioned complaints, patient was treated with INJ. Actacrez SYP. CITRALKAL in view of urinary tract infection culture reports are still pending. Patient is now symptomatically better he has had no fever spikes over the past 48 hours, patient had haematuria hence RIVAROXABAN and CLOPIDOGREL was stopped. There is planned to reinstate both the drugs on review. Patient is a known case of atrial fibrillation, the patient is being started on rate control drugs TAB. DILZEM 30 mg twice daily. Now the patient is symptomatically better hence being discharged.

DISCHARGE MEDICATION:

1. TAB. ATORVA 20 MG ONCE AT 2PM FOR 7 DAYS
2. INJ. ACTACREZ 2.25 GM IV THRICE DAILY AT 8AM 2PM 82PM FOR 2 DAYS
3. TAB. PAN 40 MG ONCE AT 7AM BBF FOR 7 DAYS
4. TAB. DILZEM 30 MG TWICE DAILY AT 8AM 2PM FOR 7 DAYS

REVIEW ON FRIDAY (11.02.2022) TO GENERAL MEDICINE OPD.
 To stop Anticoagulants on Friday

ARH1.0001227328

Name	Mr. KONDA SRINIVAS
Patient Identifier	ARHIP54589
Age	57Yr 1Mth 3Days
Sex	Male
Date of Discharge	02-Feb-2022
MLC No	
Address	10-2-282, KOTHA YASWADA KARIMNAGAR 9032756830 ,Telangana
Ward/ Bed No	First Floor, CICU , Bed no:CICU8
Primary Consultant	Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF -30%

CORONARY ANGIOGRAM DONE ON 02/02/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 02/02/2022
MEDICAL MANAGEMENT FOR RCA

R/F: T2DM

C/o chest pain radiating to back since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 57years old male patient Mr. KONDA SRINIVAS came with c/o chest pain radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF -35%, CORONARY ANGIOGRAM DONE ON 02/02/2022 - CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 02/02/2022, RCA MEDICAL MANAGEMENT. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. AMARYL M ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001227292

Name	Mrs. KALU BAI VITANKAR		
Patient Identifier	ARHIP54574	Age	55Yr 0Mth 4Days
Sex	Female	Date of Admission	01-Feb- 2022
Date of Discharge			
MLC No			
Address	5-23/1 DASANAPUR,Karimnagar,Telanga na	Ward/ Bed No	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI

SR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%]

OLD AWTMI

R/F : DENOVO T2DM

CORONARY ANGIOGRAM (04/02/2022) -CAD-TVD (LAD, LCX, RCA)

PLAN CABG WITH GRAFT TO LAD, RAMUS, RCA

C/o sudden retrosternal chest pain a/w sweating since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old female patient Mrs. KALU BAI VITANKAR came with c/o sudden retrosternal chest pain a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, SR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-25%], OLD AWMI, R/F : DENOVO T2DM , CORONARY ANGIOGRAM (04/02/2022) -CAD-TVD (LAD, LCX, RCA), PLAN CABG WITH GRAFT TO LAD, RAMUS, RCA. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

54598

ARH1.0001227351

Name

Mr.
MOHAMMA
D ABUUDH

Patient Identifier ARHIP54598

Age 59Yr 2Mth
3Days

Sex Male

Date of Admission 02-Feb-
2022

Date of Discharge
MLC No

Address 7-7-199, MUKARAM PURA
JAGTIAL
8978669371,Telangana

Ward/ Bed No First Floor,
RECOVERY
ROOM, Bed
no:RR 7

Primary Consultant Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE IWM

LV, RWMA+

MODERATE LV DYSFUNCTION, EF-50%

MILD MR/TR/PAH

R/F HTN, TOBACO, ALCOHOLIC

S/P CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

C/o gradually increasing of chest pain, radiating to the back since 6 days

K/c/o HTN

Tobaco, Alcoholic

At Admission

Afebrile

PR: 66/min

BP: 140/60 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 59 years old male patient Mr. MOHAMMAD ABUUDH came with c/o gradually increasing of chest pain, radiating to the back since 6 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE IWMI, LV, RWMA+, MODERATE LV DYSFUNCTION, EF-50% , MILD MR/TR/PAH, R/F HTN, TOBACO, ALCOHOLIC, S/P CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001227352

Name

Mrs. M D SHEMIY

Patient Identifier

ARHIP54602

Age

47Yr 2Mth
5Days

Sex

Female

Date of

Admission

02-Feb-
2022

Date of Discharge

06-Feb-2022

MLC No

Address

21-368/1, KAKATHIYA COLONY
MANCHERIAL
8498974314,Telangana

Ward/Bed No

First Floor,
RECOVERY
ROOM, Bed
no:RR 4

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

Surgeons

Dr. Vidya Sagar A--
CARDIOLOGY

**Anesthesiologi
sts**

Diagnosi
S

Diagnosis

Disease	Disease Type
CAD-NSTEMI,NO TLT,SR,MODERATE LV SYS DYSFUNCTION,EF:40%, RF:HTN, OLD AWMi,S/P-PTCA TO LAD(2019).CAG DONE ON 5/02/2022-CAD-LAD PROXIMAL MILD ISR PLAN: MEDICAL MANAGEMENT.	

ARH1.0001226900		Name	Mr. SAYYAD KHADER
Patient Identifier	ARHIP54433	Age	50Yr 0Mth 17Days
Sex	Male	Date of Admission	21-Jan-2022
Date of Discharge			
MLC No			
Address	7-4-74, SUBRAHMANYAM NAGAR, VEMULAWADA, RAJANNA SIRICILLA, Karimnagar, Telangana	Ward/ Bed No	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant- Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

CHRONIC RHEUMATIC HEART DISEASE, SEVERE MS+ SEVERE MR + SEVERE TR in AF

Surgery: MVR WITH SJ NO. 27 mm, MECHANICAL VALVE +DEVEGA'S TV REPAIR+LAA LIGATION DONE ON 02/02/2022.

C/o shortness of breath on exertion since 1 month

AT ADMISSION:

Pt c/c

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. SAYYAD KHADER came with c/o shortness of breath on exertion since 1 month. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE, SEVERE MS+ SEVERE MR + SEVERE TR in AF, Surgery: MVR WITH SJ NO. 27 mm, MECHANICAL VALVE + DEVEGA'S TV REPAIR+LAA LIGATION DONE ON 02/02/2022. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, NO VALVULAR/PARAVALVULAR LEAK, NO LV RWMA, MODERATE TR/PAH, MILD AR, FAIR LV FUNCTION, EF-50%, NO PE/CLOT/VEG

BMI is 19.3 kg/m².

Sr. Creatinine report on 03/02/2022 1.1 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 2 MG ONCE DAILY DAY AT 7PM TO CONTINUE FOR LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND-VIT ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. CORDARONE 200 MG THRICE DAILY AT 8AM, 2PM AND 8PM TO CONTINUE.
- 5) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.
- 6) TAB. DOLO 650 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

54612 SANJAY 24

DKA

LRTI

C/o sudden onset of fever, SOB followed by altered sensorium

K/c/o T2DM

AT ADMISSION:

Patient drowsy, oriented, coherent

PR: 98/min

BP: 80/50mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 24 years old male patient SANJAY came with c/o sudden onset of fever, SOB followed by altered sensorium. All necessary investigations were done and diagnosed as DKA, LRTI. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. FEROALFA-CV 300 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. DALACIN 300 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. BILAHENZ-M ONCE DAILY AT 2PM FOR 5 DAYS
- 5) INJ. TOUJEO 20 Units ONCE DAILY AT 7AM BBF TO CONTINUE

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001114816

Name	Mrs. M BHOOLAXMI		
Patient Identifier	ARHIP54629	Age	72Yr 4Mth 11Days
Sex	Female	Date of Admission	05-Feb- 2022
Date of Discharge			
MLC No			
Address	VIDYA NAGAR,Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ADHF, MILD MR

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

RF: HTN, DENOVO T2DM

CORONARY ARTERY DISEASE, OLD AWM

S/P PTCA+DES TO PROXIMAL LAD WITH XIENCE ALPINE 3.5 X 18 mm AND
DISTAL LAD WITH BIOMIME 2.75 X 13 mm (29/09/2016)

C/o chest pain and palpitations since 1 day

K/C/O HTN, DENOVO T2DM

S/P PTCA+DES TO LAD (2016)

AT ADMISSION:

Afebrile

PR: 82/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 72years old female patient Mrs. M BHOOLAXMI came with c/o chest pain and palpitations since 1 day. All necessary investigations were done and diagnosed as ADHF, MILD MR, ACCELERATED HYPERTENSION, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, RF: HTN, DENOVO T2DM, CORONARY ARTERY DISEASE, OLD AWMi, S/P PTCA+DES TO PROXIMAL LAD WITH XIENCE ALPINE 3.5 X 18 mm AND DISTAL LAD WITH BIOMIME 2.75 X 13 mm (29/09/2016). Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ROZAGOLD 10MG ONCE DAILY AT 8PM TO CONTINUE.
- 2) TAB. PROLOMET-R 25/2.5MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. RAMISTAR 2.5MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PANTOCID DSR 40MG ONCE DAILY AT 7AM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001227308		Name	Mr. REPAKUL PUNAMCHANDHA R
Patient Identifier	ARHIP54578	Age	41Yr 1Mth 6Days
Sex	Male	Date of Admission	01-Feb-2022
Date of Discharge			
MLC No			
Address	1-49/27, BORIGAM KOMARAM BHEEM 9390009017 ,Telangana	Ward/Bed No	First Floor, HDU, Bed no:HDU 4
Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE, ACUTE AWMI,
SEVERE LV DYSFUNCTION, EF-32%
S/P TLT WITH INJ.TENECTEPLASE (31/01/2022) OUTSIDE
R/F: HTN, DENOVO T2DM, ALCOHOL
CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-TVD (LAD, LCX, RCA)
PTCA+DES TO LAD WITH 2.5 X 44 MM METAFOR DONE ON 04/02/2022
MEDICAL MANAGEMENT FOR PDA & OM (Thin Vessels)

C/o left sided chest pain, radiating to back, which is sudden in nature

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 41years old male patient Mr. REPAKUL PUNAMCHANDHAR came with c/o left sided chest pain, radiating to back, which is sudden in nature. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SEVERE LV DYSFUNCTION, EF-32%, S/P TLT WITH INJ.TENECTEPLASE (31/01/2022) OUTSIDE, R/F: HTN, DENOVO T2DM, ALCOHOL, CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-TVD (LAD, LCX, RCA), PTCA+DES TO LAD WITH 2.5 X 44 MM METAFOR DONE ON 04/02/2022, MEDICAL MANAGEMENT FOR PDA & OM (Thin Vessels). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. RAMISTAR 2.5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 8) TAB. ZORYL M1 FORTE ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001106
563

Name

Mr.
ANUMALA
GOVARDH
AN

**Patient
Identifier**

ARHIP54604

Age

45Yr
8Mth
4Days

Sex

Male

**Date of
Admission**

03-
Feb-
2022

**Date of
Discharge**

06-Feb-2022

MLC No

Address 3-

67,RAMADUGU,DESHRAJPALLE,Karimnagar,

Ward/Bed No First
Floor,

Telangana

HDU,
Bed
no:HD
U 1

Primary Consultant Dr. Vidya Sagar A--CARDIOLOGY
Surgeons Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
CAD EVOVLED AWMi, NO TLT. SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF:45%. RF;T2DM. OLD CAD S/P CAG(2012) OLD CVA-RT. HEMIPARESIS. CAG DONE ON 5/02/2022. CAD-DVD(LAD,RCA). PLAN:CABG WITH GRAFT TO LAD AND RCA.	

C/o Retrosternal chest pain since 1day

At Admission

Afebrile

PR: 115/min

BP: 140/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 45 years old male patient **Mr. ANUMALA GOVARDHAN** came with c/o retrosternal chest pain since 1day . All necessary investigations were done and diagnosed as CAD EVOLED AWMi, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF:45%, RF;T2DM. OLD CAD S/P CAG(2012), OLD CVA-RT. HEMIPARESIS. CAG DONE ON 5/02/2022. CAD-DVD(LAD,RCA). PLAN:CABG WITH GRAFT TO LAD AND RCA.. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. AMARYL 1 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001227389

Name

Mrs.
KANTHAMM
A MERUGU

Patient Identifier

ARHIP54611

Age

55Yr
0Mth
4Days

Sex

Female

**Date of
Admission**

04-Feb-
2022

**Date of Discharge
MLC No**

Address

SULTHANABAD,PEDDAPALLY,Other,Telanga
na

**Ward/Bed
No**

First
Floor,
SICU,
Bed
no:SICU
6

Primary Consultant

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE-NSTEMI, NO TLT

SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-55%]

R/F : HTN

CORONARY ANGIOGRAM (06/02/2022) -CAD- mid disease

ADVICE MEDICAL MANAGEMENT

C/o chest pain, radiating to back a/w SOB since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 100/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 55 years old female patient Mrs. KANTHAMMA MERUGU came with c/o chest pain, radiating to back a/w SOB since 1 month. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-NSTEMI, NO TLT, SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-55%], R/F : HTN, CORONARY ANGIOGRAM (06/02/2022) -CAD- mid disease, ADVICE MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TAZLOC-H 40 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. METFORMIN 500 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
7. SYP. CREMAFFIN 2 tsp ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001
227420

Name

Mr.
KOM
MU
LING
AIAH

Patient Identifier

ARHIP54621

Age

65Yr
0Mth
3Days

Sex

Male

Date of Admission

04-Feb-2022

Date of Discharge MLC No

Address

HABSIPUR,JAGITYAL,T
elangana

Ward/Bed No

First
Floor
,
CICU
, Bed
no:CI
CU3

Primary Consultant

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-32%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (RCA)

TPI+ PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR DONE ON 04/02/2022

C/o chest pain a/w SOB and vomiting since 1 day

K/C/O HTN

AT ADMISSION:

Afebrile

PR: 101/min

BP: 120/70 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. KOMMU LINGAIAH came with c/o chest pain a/w SOB and vomiting since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-32%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (RCA), TPI+ PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR DONE ON 04/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
27235

Name

Mr.
YADAI
AH
THULU
VA

**Patient
Identifier**

ARHIP54557

Age

52Yr
0Mth
8Days

Sex

Male

**Date
of
Admission**

30-
Jan-
2022

**Date
of
Discharge
MLC
No**

Address

1-42,
MYSAMPALLI ,SI
DDIPET,Telang
ana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CI
CU9

**Primary
Consultant**

Dr. Vidya Sagar
A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF: 35%

R/F: HTN, T2DM

OLD CVA

CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 04/02/2022

C/o giddiness since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. YADAAIAH THULUVA came with c/o giddiness since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF: 35%, R/F: HTN, T2DM, OLD CVA, CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 04/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ARORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. TELMA 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. EMBETA X2 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) INJ HUMAN MIXTARD 30/70 20 U S/C AT 8AM, 10 U S/C AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
26966

**Patient
Identifier**

ARHIP54459

Sex

Female

**Expired
Date**

29-Jan-2022

MLC No

Address

MANCHERIAL,Tandur,T
elangana

Primary

Dr SOMASHEKAR

**Na
m
e**

Mrs.
SHANTHA
KUMARI
SHARADU

Age

64Yr 0Mth
6Days

**Date of
Admission**

23-Jan-2022

**Ward/Bed
No**

First Floor, CT
POST, Bed
no:CT 5

Consultant

Consultant

K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C
T SURGERY

S

Surgeons

Dr SOMASHEKAR
K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C
T SURGERY

Anesthesiologists

Dr.
K.S.D.KRISHNA
KIRAN--
ANAESTHESIO
LOGY

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ,LMCA CRITICAL STENOSIS. LV DYSFUNCTION.HYPERTENSION.	
SURGERY :EMERGENCY CORONARY ARTERY BYPASS GRAFTING[SVG TO LAD ,RI,PDA]+IABP DONE ON 27/01/2022	

C/o chest pain, giddiness since 1 month

AT ADMISSION:

PR: 88/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 62 years old male patient MADHUNAIAH came with c/o slurring of speech a/w right sided weakness of both upper limb and lower limb. K/c/o CAD-Old IWMI. All necessary investigations were done and diagnosed as ACUTE INTRAPARENCHYMAL BLEED. Managed conservatively. Patient developed bradycardia and hypotension, emergency intubation was done and connected to Mechanical Ventilator support on SIMV mode with fio2-100%. Inotropes support were started for Hypotension. Patient condition was explained to

patient attendants. On 26/12/2020 at 10.50 am patient had cardiac arrest, BP not recordable with inotropes support, immediately CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 11.20am on 26/12/2020.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO ACUTE INTRAPARENCHYMAL BLEED

54587

ARH1.00 0122732 2	Name		Mr. CHILA GANI THIR UPAT HI		
	Pati ent Iden tifie r	ARHIP54587		Age	53Y r 4Mt h 24D ays
	Sex	Male		Dat e of Ad mis sion	02- Feb- 202 2
	Dat e of Disc har ge MLC No				
	Add ress	H.NO:8-5-101/1/ A,LAXMINAGAR,KARIMNAGA R,Telangana		War d/ Bed No	First Floo r, CIC U , Bed no: CIC U13
	Pri mar y Con sult ant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF 35%.

DKA

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN : CABG/MEDICAL MANAGEMENT

RENAL ANGIOGRAM: RIGHT RENAL ARTERY OSTIAL MILD DISEASE

LEFT RENAL ARTERY OSTIOPROXIMAL SIGNIFICANT STENOSIS

PLAN: PTA + STENT TO LEFT RENAL ARTERY

-

C/o sudden and progressive shortness of breath since 1 day associated with profuse sweating and left sided chest pain

AT ADMISSION:

Afebrile

PR: 101/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 53 years old male patient Mr. CHILAGANI THIRUPATHI came with c/o Sudden and progressive shortness of breath since 1 day associated with profuse sweating and left sided chest pain. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF 35%, DKA, R/F: T2DM, CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-TVD (LAD, LCX, RCA), PLAN : CABG/MEDICAL MANAGEMENT, RENAL ANGIOGRAM: RIGHT RENAL ARTERY OSTIAL MILD DISEASE, LEFT RENAL ARTERY OSTIOPROXIMAL SIGNIFICANT STENOSIS, PLAN: PTA + STENT TO LEFT RENAL ARTERY. Post procedure is uneventful.

Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) CAP. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) INJ HUMAN MIXTURED 30/70 22 Units AT 8AM, 18 Units AT 8PM
CONTINUE
- 8) TAB. CARDACE 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012
27380

**Na
me**

Mr.
RAMANARE
DDY
CHALLA

**Patient
Identifier**

ARHIP54608

Age

54Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

03-
Feb-
2022

**Date of
Discharge
MLC No**

Address

HUSNABAD,,Husnabad,T
elangana

**Ward/
Bed No**

First
Floor
,
SICU,
Bed
no:SI
CU 7

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3V ASTRA 2.75 X 20 MM DONE ON 05/02/2022

C/o chest pain since 3 days a/w SOB

AT ADMISSION:

Afebrile

PR: 96/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old male patient Mr. RAMANAREDDY CHALLA came with c/o chest pain since 3 days a/w SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: T2DM, CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3V ASTRA 2.75 X 20 MM DONE ON 05/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. ZORYL M1 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) INJ. HUMAN INSULATARD 8U S/C TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00011 51566		Name	Mrs. NADIME TLA ANDAM MA	
Patient Identifier	ARHIP54623	Age	63Yr 10Mth 3Days	
Sex	Female	Date of Admission	04-Feb-2022	
Date of Discharge				
MLC No				
Address	1- 82,WALLAMPAHAD,Karimnagar,Telangana	Ward/Bed No	First Floor , MICU , Bed no:M ICU 9	
Primary Consultant	Dr. Vidya Sagar A--			

CORONARY ARTERY DISEASE-NSTEMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (07/02/2022) -CAD- mild disease in LAD, RCA

PLAN MEDICAL MANAGEMENT

C/o chest pain, radiating to back a/w SOB since 3 months

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 63 years old female patient Mrs. NADIMETLA ANDAMMA came with c/o chest pain, radiating to back a/w SOB since 3 months. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-NSTEMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (07/02/2022) -CAD- mid disease in LAD, RCA, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001
227422

Name

Mr.
MAHEND
HAR G

**Patient
Identifier**

ARHIP54627

Age

39Yr
0Mt
h
3Days

Sex

Male

**Date
of
Admission**

05-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

KMR,Karimnagar,T
elangana

**Ward/
Bed
No**

First
Floor,
MIC
U,
Bed
no:
MIC
U 7

**Primary
Consultant**

Dr. Vidya Sagar
A--

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 29 **MM METAFOR DONE ON 05/02/2022**

C/o sudden onset chest pain since 1 day a/w mild SOB and sweating

K/c/o HTN

AT ADMISSION:

Afebrile

PR: 117/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 39 years old male patient Mr. MAHENDHAR G came with c/o sudden onset chest pain since 1 day a/w mild SOB and sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 05/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 29 MM METAFOR DONE ON 05/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CARDACE 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
227352

Name

Mrs.
M D
SHE
MIY

Patient Identifier

ARHIP54602

Age

47Yr
2Mth
6Days

Sex

Female

Date of Admission

02-
Feb-
2022

**Date of Discharge
MLC No**

06-Feb-2022

Address

21-368/1,
KAKATHIYA
COLONY
MANCHERIAL
8498974314,T
elangana

Ward/Bed No

First
Floor,
RECOVER
ROOM,
Bed
no:RR
4

Primary Consultant

Dr. Vidya
Sagar A--
CARDIOLOGY

Consultants

Surgeons

Dr. Vidya
Sagar A--
CARDIOLOGY

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

CAD-NSTEMI,NO TLT,

SR,MODERATE LV SYS DYSFUNCTION,EF:40%,

RF:HTN,

OLD AWTMI,S/P-PTCA TO LAD(2019).CAG DONE ON 5/02/2022-CAD-LAD PROXIMAL MILD ISR

PLAN: MEDICAL MANAGEMENT.

C/o chest pain since 4 days a/w SOB, sweating

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 47 years old female patient Mrs. M D SHEMAIY came with c/o chest pain since 4 days a/w SOB, sweating. All necessary investigations were done and diagnosed as CAD-NSTEMI, NO TLT, SR, MODERATE LV SYS DYSFUNCTION, EF:40%, RF: HTN, OLD AWTMI, S/P-PTCA TO LAD(2019). CAG DONE ON 5/02/2022-CAD-LAD PROXIMAL MILD ISR, PLAN: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TAZOLAC 40MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. STARPRESS AM 50/5 ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001 227419		N a m e	Mrs. SATAYMMA AKULA	
Patient Identifier	ARHIP54625		Age	58Yr 0Mt h 4Da ys
Sex	Female		Date of Admission	04- Feb- 202 2
Date of Discharge	07-Feb-2022			
MLC No				
Address	KATLAKINTA,MEDIPALLI,JAGTIAL,Other,Telangana		Ward/Bed No	First Floor, MIC U, Bed no: MIC U 12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		Consultants	
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY		Anesthesiologists	
Diagnosis	<div><div>Diagnosis</div><div><div>Disease</div><div>Disease Type</div></div></div>			

CAD-AWMI,SR,MILD LV DYSFUNCTION
MILD MR/TR, EF 46%
R/F:HTN
CAG DONE ON 07/02/2022
CAD -DVD(LAD AND LCX)
PLAN CABG.

C/o sudden onset of chest pain, radiating to back a/w vomiting since 1 day
K/c/o HTN

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 58 years old female patient Mrs. SATAYMMA AKULA came with c/o sudden onset of chest pain, radiating to back a/w vomiting since 1 day. All necessary investigations were done and diagnosed as CAD-AWMI,SR,MILD LV DYSFUNCTION, MILD MR/TR, EF 46%, R/F:HTN, CAG DONE ON 07/02/2022, CAD -DVD(LAD AND LCX), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

54647

ARH1.00012
27390

**Na
me**

Mr.
RAJAMO
GILI
GUDI

**Patient
Identifier**

ARHIP54610

Age

47Yr
0Mth
4Days

Sex

Male

**Date of
Admiss
ion**

03-
Feb-
2022

**Date of
Discharge
MLC No**

Address

H.NO:24-
7,MANDAMARRI,MANCHIRAIL,Other,
Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CI
CU7

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 04/02/2022 - CAD-DVD (RCA,LAD)

PRIMARY PTCA+DES TO RCA WITH METAFOR 3.5 X 32 MM DONE ON 04/02/2022
PTCA+DES TO LAD WITH XIENCE XPEDITION 3.0 X 23 MM DONE ON 07/02/2022

C/o sudden onset of chest pain since 1 hr, radiating to left arm a/w mild SOB
and sweating

AT ADMISSION:

Afebrile

PR: 54/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 47 years old male patient Mr. RAJAMOGILI GUDI came with c/o sudden onset of chest pain since 1 hr, radiating to left arm a/w mild SOB and sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 04/02/2022 – CAD-DVD (RCA,LAD), PRIMARY PTCA+DES TO RCA WITH METAFOR 3.5 X 32 MM DONE ON 04/02/2022, PTCA+DES TO LAD WITH XIENCE XPEDITION 3.0 X 23 MM DONE ON 07/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) SYP. CREMAFFIN 2 tsp ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122749
0

Name

Mr.
CHALLA
RAJANNA

**Patient
Identifier**

ARHIP54648

Age

61Yr
2Mth
3Days

Sex

Male

**Date of
Admission**

07-
Feb-
2022

**Date of
Discharge
MLC No**

Address

4-131,
DHARMAPURI
JAGTIAL
9849193136 ,Tel
angana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 4

**Primary
Consultant**

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT

SR, FAIR LV SYSTOLIC FUNCTION, EF-56%

CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-DVD (RCA, LAD)

PRIMARY PTCA+DES TO RCA WITH 3V ASTRA 3.5 X 24 MM DONE ON 07/02/2022
MEDICAL MANAGEMENT FOR A DIAGONAL (THIN VESSEL)
R/F: HTN, T2DM

C/o chest pain since 1 day a/w SOB

K/c/o T2DM, HTN

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 61years old male patient Mr. CHALLA RAJANNA came with c/o chest pain since 1 day a/w SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, FAIR LV SYSTOLIC FUNCTION, EF-56%, CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-DVD (RCA, LAD), PRIMARY PTCA+DES TO RCA WITH 3V ASTRA 3.5 X 24 MM DONE ON 07/02/2022, MEDICAL MANAGEMENT FOR A DIAGONAL (THIN VESSEL). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) INJ HUMAN MIXTURED 30/70 24Units AT 8AM AND 16Units AT 8PM S/C 10 min before food TO CONTINUE
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
007870

Name

Mrs
. M
VIJ
AY
A
LAX
MI

Patient Identifier

ARHIP54688

Age

65Yr
8Mth
4Days

Sex

Female

Date of Admission

09-Feb-2022

**Date of Discharge
MLC No**

Address

1-15/6/5, ELL
GOUDTHODA, KAGAZ
NAGAR, Adilabad(Adilabad), Andhra Pradesh

Ward /Bed No

First Floor,
CICU ,
Bed no: CI
CU10

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CARDIOGENIC SHOCK (? SEPSIS)
ADHF
SEVERE LV SYSTOLIC DYSFUNCTION, EF -28%
R/F : HTN, T2DM

OLD CAD, S/P PTCA + DES TO LAD (2011)

C/o Shortness of breath on exertion, fever with chills since 3 days
Generalised weakness, bilateral pedal oedema

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old female patient Mrs. M VIJAYA LAXMI came with c/o shortness of breath on exertion, fever with chills since 3 days, generalised weakness, bilateral pedal oedema. All necessary investigations were done and diagnosed as CARDIOGENIC SHOCK (? SEPSIS), ADHF, SEVERE LV SYSTOLIC DYSFUNCTION, EF - 28%, R/F : HTN, T2DM, OLD CAD, S/P PTCA + DES TO LAD (2011). Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA

DISCHARGE MEDICATION:

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AZTOR 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. ALDACTONE 25MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
5. INJ. HUMAN INSULATARD 10U S/C TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

6. TAB: GLYCOMET 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. CAP: CEFRINE 300 MG TWICE DAILY AT 8AM AND 8PM FOR 1 WEEK.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

54622

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Name

Mr.
ABDUL
AHAMAN

**Pati
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ARHIP54622

Age

44
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Sex

Male

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**Pri
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Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, EVOLVED AWMI

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%

R/F: HTN, T2DM, SMOKING, ALCOHOL

CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-SVD (LAD)

PTCA+2DES TO LAD WITH 3.0 X 37 MM METAFOR, 3.5 X 13 MM METAFOR DONE ON
07/02/2022
COPD

C/o Sudden onset of chest pain since 1 day associated with heaviness in chest

AT ADMISSION:

Afebrile

PR: 78/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 44 years old male patient Mr. ABDULRAHAMAN came with c/o sudden onset of chest pain since 1 day associated with heaviness in chest. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, EVOLVED AWTMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, R/F: HTN, T2DM, SMOKING, ALCOHOL, CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-SVD (LAD), PTCA+2DES TO LAD WITH 3.0 X 37 MM METAFOR, 3.5 X 13 MM METAFOR DONE ON 07/02/2022, COPD. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RAMISTAR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

- 7) CAP. ABFLO 100 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 9) TAB. RECLIDE XR 60 MG ONCE DAILY AT 8AM TO CONTINUE.
- 10) DUOLIN INHALER 2 PUFFS TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
27511

Name

Mr.
DAWANAPALLI
YELLAIAH

Patient Identifier

ARHIP54652

Age

79Yr
1Mth
3Days

Sex

Male

Date of Admission

07-Feb-2022

Date of Discharge MLC No

Address

3-36,
ANKUSHAP
OOR
RAJANNA
799542263
3 ,Telangana

Ward/ Bed No

First
Floor
,
HDU
,
Bed
no:HDU 1

Primary Consultant

Dr. Vidya
Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI

MOBITZ TYPE-II BLOCK

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-55%

CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.0 X 44 MM METAFOR DONE ON 07/02/2022
TPI DONE ON 07/02/2022 & REMOVED ON 09/02/2022

C/o sudden fall 2 episodes a/w giddiness

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 79 years old male patient Mr. DAWANAPALLY YELLAIAH came with c/o sudden fall 2 episodes a/w giddiness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, MOBITZ TYPE-II BLOCK, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-55%, CORONARY ANGIOGRAM DONE ON 07/02/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.0 X 44 MM METAFOR DONE ON 07/02/2022, TPI DONE ON 07/02/2022 & REMOVED ON 09/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 70MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) TAB. VOGS 0.3 MG ONCE DAILY AT 8AM BEFORE FOOD TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00
0122746
5

**N
a
m
e**

Mr.
NANDAIA
H
POCHAMP
ELLY

**Patient
Identifi
er**

ARHIP54642

Age

78
Yr
0M
th
5D
ay
s
06
-
Fe
b-
20
22

Sex

Male

**Date of
Admissi
on**

**Date of
Dischar
ge
MLC No**

10-Feb-2022

**Addres
s**

POTHAREDDIPETA,HUZURABAD,KARIMNAG
AR,Huzurabad,Telangana

**Ward/
Bed No**

Fir
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Flo
or,
MI
CU
,
Be
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no
:MI
CU
8

**Primary
Consult
ant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consult
ants**

**Surgeo
ns**

Dr. Vidya Sagar A--CARDIOLOGY

**Anesthe
siologist
s**

**Diagnosi
S**

Diagnosis



Diseas e	Disease Type
-------------	-----------------

CORONARY ARTERY DISEASE,ACUTE INFERIOR WALL MYOCARDIAL INFARCTION,NO TLT MILD
MR,SR MODERATE LV DYSFUNCTION EF:38%
R/F:HYPERTENSION
CAG DONE ON 8/2/2022-2VD(LAD,LCX)
ADVICE- CABG.

C/o chest pain since 3 days

K/c/o HTN

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 78 years old male patient Mr. NANDAIAH POCHAMPELly came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, NO TLT MILD MR, SR MODERATE LV DYSFUNCTION EF:38%, R/F: HYPERTENSION, CAG DONE ON 8/2/2022- 2VD(LAD, LCX). ADVICE- CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. LOSAR 25MG ONCE DAILY AT 2PM TO CONTINUE.
5. CAP. ANGISPAN-TR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
6. SYP. LOOZ 30 ml ONCE DAILY AT 8PM

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001196
668

**Na
me**

Mr.
RAJAELLIAH
SAVANAPEL
LI

**Patient
Identifier**

ARHIP54683

Age

55Yr
6Mth
17Days
09-Feb-
2022

Sex

Male

**Date of
Admission**

**Date of
Discharge
MLC No**

Address

MUSKANIPET,Sircilla,Telan
gana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
4

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

HYPERTENSIVE EMERGENCY WITH ACUTE PULMONARY OEDEMA
SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

R/F : HTN,T2DM

ACUTE ON CKD

C/o Grade- III shortness of breath since 2 days associated with profuse settings and palpitations

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 136/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. RAJAELLIAH SAVANAPELLI came with c/o grade- III shortness of breath since 2 days associated with profuse settings and palpitations. All necessary investigations were done and diagnosed as HYPERTENSIVE EMERGENCY WITH ACUTE PULMONARY OEDEMA, SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], R/F : HTN,T2DM, ACUTE ON CKD. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. MINIPRESS-XL 5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. BETALOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. NICARDIA-XL 30MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
8. TAB. KETO CHECK TWICE DAILY AT 9AM AND 8PM TO CONTINUE.
9. TAB. CUDCE TWICE DAILY AT 9AM AND 9PM TO CONTINUE.
10. TAB. LOYZIDE 40 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS/PLBS REPORTS

ARH1.000
1227588

Name

Mr.
MAL
LAIA

H N

Patient Identifier

ARHIP54687

Age

70Y
r
OMt
h
1D
ays
09-
Feb
-
202
2

Sex

Male

Date of Admission

Expired Date MLC No

10-Feb-2022

Address

KAMANPUR,
PEDDAPLLI,Karimnagar,Telangana

Ward/Bed No

Firs
t
Flo
or,
MIC
U,
Be
d
no:
MIC
U 9

Primary Consultant Surgeons

DR. SRI KARAN
UDDESH --INTERNAL
MEDICINE

Consultants

Anesthesiologists

Diagnosis



Diagnosis

Disease	Disease Type
SEPSIS WITH MODS SECONDARY TO PYOGENIC LIVER ABSCESS.	

C/o shortness of breath grade III-IV since 1 week, aggravated since 1-2 days
H/o fever 1 month ago
H/o abdominal distension since 1 month
H/o decreased appetite since 1 month

AT ADMISSION:

Afebrile, tachypneic

PR: 110/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2, tachycardia observed

RR: 28/min

SPO2: 98% with 4 Ltr O2/min

P/A: Distended diffuse tenderness was observed to superficial palpation, gross hepatomegaly was observed

A 70 years old male Mr. MALLAIAH patient presented with the above-mentioned complaints. An ultrasound abdomen revealed multiple liver abscesses CT abdomen was done, which showed features suggestive of pyogenic liver abscess. General Surgery consultation was done and was advised pigtail catheterisation after patient stabilization. Patient was started on INJ. MEROPENEM INJ. THIAMINE and INJ. METROGYL. Patient condition worsened within hours of hospitalization. Patient had no urine output patient, had severe respiratory distress, so patient was intubated in view of severe respiratory distress. Inotropic support was started in view of hypotension. At 6:30 p.m. patient had a sudden cardiac arrest and CPR was initiated according to ACLS guidelines. Despite best efforts patient could not be revived, hence declared dead at 6 p.m. 6:37 p.m. on 10/02/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH MODS
SECONDARY TO PYOGENIC LIVER ABSCESS

ARH1.000118
7735

**Na
me**

Mr. GANGARAM
KONA

**Patient
Identifier**

ARHIP54497

Age

66Yr
0Mth
30Da
ys
25-
Jan-
2022

Sex

Male

**Date of
Admission**

**Expired
Date
MLC No**

31-Jan-2022

Address

LUXETIPET,Mancherial,Tela
ngana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MI
CU 2

**Primary
Consultant**

Dr. RAMCHANDER
TORREM(MD (General
Medicine),DM

Consultants

Nephrology(NIMS),Associate Consultant-
Nephrologist--
NEPHROLOGY

Surgeons

Anesthesiologists

Diagnosis



Diagnosis

IT PROBLEM	
	Pd

ACUTE PYREXIA
ACUTE ON CKD
HTN
CAD,S/P PTCA
RA.

C/o fever since 10 days

H/o CKD, HTN, CAD

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

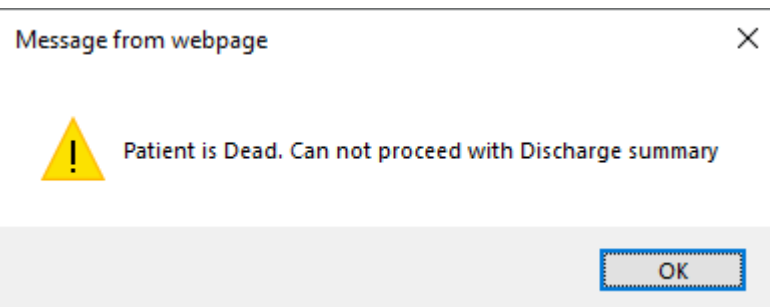
A 66 years old male patient Mr. GANGARAM KONA presented to hospital with c/o fever since 10 days. All necessary investigations were done and diagnosed

as ACUTE PYREXIA, ACUTE ON CKD, HTN, CAD,S/P PTCA, RA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
- 1.INJ.CONVICTUS 1.5 GM INTRA VENOUS TWICE DAILY AT 8AM AND 8 PM FOR 7 DAYS
 - 2.INJ.SODA BICARB 25 ML INTRA VENOUS TWICE DAILY AT 8AM AND 8 PM FOR 7 DAYS
 - 3.INJ.GLEVO 500MG INTRA VENOUS ONCE DAILY AT 8AM FOR 7 DAYS
 - 4.INJ.PAN 40 MG INTRA VENOUS ONCE DAILY AT 8AM FOR 7 DAYS
 - 5.INJ.OPTINEURON 1AMP ONCE DAILY AT 2PM FOR 7 DAYS
 - 6.INJ.PARACETAMOL 1GM INTRA VENOUS TWICE DAILY AT 8AM AND 8 PM FOR 7 DAYS
 - 7.INJ.ZOFER 4MG INTRA VENOUS THRICE DAILY AT 8AM , 2PM AND 8 PM FOR 7 DAYS
 - 8.TAB.MODALERT10 MG PO ONCE DAILY AT 2PM FOR 7 DAYS
 - 9.TAB.KETO CHECK 1 TAB PO THRICE DAILY AT 8AM , 2PM AND 8 PM FOR 7 DAYS
 - 10.TAB.CUDEC FORTE 1 TAB PO THRICE DAILY AT 8AM , 2PM AND 8 PM FOR 7 DAYS
 - 11.TAB.ROZALET 10 MG PO ONCE DAILY AT 10PM BED TIME FOR 7 DAYS
 - 12.TAB.ECOSPRIN 150 MG PO ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN NEPHROLOGY OPD



ARH1.0001187 735	ARHIP545 24	Mr. GANGARA M KONA	MIC U 4	Dr. RAMCHANDE R TORREM
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C/o fever since 5dya, decreased food intake, drowsiness ,alterd sensorium since few days.

ADMISSION VITALS:

Patient is drowsy, arousable to call

PR-102/min

BP-130/90mmhg

RR-22/mmin

RS-BAE+

CVS-S1S2+

P/A-soft

A 66years old male patient presented to ER with c/o fever since 5dya, decreased food intake, drowsiness ,alterd sensorium since few days. All necessary investigations were done and diagnosed as CHRONIC `ISEASE,CVA,CAD. NEUROLOGY consultaions was taken in view of patient had one episode of seizures and followed as advice. Patient was intubated in view low saturation,low GCS on 31/01/2022. Patient had sudden cardiac arrest on 31/01/2022 at 8.30am, immediately CPR was intiaded as per ACLS protocols,but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 8.52AM on 31/01/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO SEPTIC SHOCK DUE TO
CKD,CAV,CVA.

54252

Complaint of giddiness since 6.1.2022 associated with vomiting, slurring of
speech and cough.

S/P CABG IN JAN'2021.

K/C/O HYPERTENSION and TYPE II DIABETES MELLITUS.

ON ADMISSION

Pt is drowsy.

Afebrile

PR-77/min

BP-160/100mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-100%

A 51 years old male patient Mr. GANGARAPU MOGILI is a k/c/o HYPERTENSION and TYPE II DIABETES MELLITUS and s/o CABG presented to hospital with c/o giddiness since 6.1.2022 associated with vomiting, slurring of speech and cough. All necessary investigations were done and diagnosed as MULTIPLE ACUTE INFARCTS IN POSTERIOR CIRCULATION. General physician consultation was taken and advise followed. 2D Echo report showed Concentric LVH, s/p CABG, paradoxical septal motion, Grade I diastolic dysfunction, mild LV dysfunction, EF-45%. Managed conservatively. On 19/01/2022 Patient went to bradycardia. CPR started according to ACLS guidelines. Inj. Adrenaline & Inj Atropine given, but patient not revived, then 3 cycles of CPR done Inj. Adrenaline & Inj Atropine repeated, CPR continued. Patient not revived

Rhythm was pulse

Despite efforts, patient could not be revived back, rhythm was asystole

ECG showed flat lines

Pupils-b/l dilated and fixed

Hence patient was declared as dead at 7.19 AM

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO POSTERIOR CIRCULATION
STROKE WITH UNCONTROLLED TYPE II DM, S/P CABG

54685

RAMACHANDRAM

HEART FAILURE WITH REDUCED EJECTION FRACTION
SEVERE MITRAL REGURGITATION

Shortness of breath

History of progressive dyspnoea since 10 days

AT ADMISSION:

Afebrile

PR: 101/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% with 3 Lit O2

P/A: Soft

Discussion

A 78 years old male patient Mr. RAMCHANDRAM presented with the above-mentioned complaints. 2D Echo was done which showed global hypokinesia of left ventricle and severe mitral regurgitation, EF of 28%. Patient was diagnosed to have heart failure with reduced ejection fraction. Patient was started with TAB. VYMADA 50 mg 1-0-1 INJ. LASIX 40 mg IV 1-0-0 and fluid restrictions. Now the patient symptomatically better hence being discharged with the following medication.

DISCHARGE MEDICATION:

1. TAB. VYMADA 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
2. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE
3. TAB. CARVEDILOL 3.125 TWICE DAILY AT 8AM AND 8PM TO CONTINUE

REVIEW AFTER 1 MONTH TO GENERAL MEDICINE OPD WITH RP-II report

Total fluids @ 1 Ltr/day
Low salt diet

ARH1.0001
227421

Name

Mrs.
SHAH
EDA
BEGU
M

Patient Identifier

ARHIP54628

Age

56Yr
0Mth
6Days

Sex

Female

Date of Admission

05-Feb-2022

Date of Discharge MLC No

Address

8-21
POLASA,Karimnagar,
Telangana

Ward/Bed No

First Floor
,
CICU
, Bed no:CICU8

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-20%

R/F: T2DM, HTN

CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3V ASTRA 3.0 X 24 MM DONE ON 08/02/2022

C/o chest pain since 1 day a/w SOB, sweating

AT ADMISSION:

Afebrile

PR: 100/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old female patient Mrs. SHAHEDA BEGUM came with c/o chest pain since 1 day a/w SOB, sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-20%, R/F: T2DM, HTN, CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3V ASTRA 3.0 X 24 MM DONE ON 08/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLAVIX 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. IVABRAD 5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) INJ HUMAN MIXTARD 30/70 24 U S/C AT 8AM, 16 U S/C AT 8PM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54616

ARH1.0001
227406

Name

Mr. K
YELL
AIAH

**Patient
Identifier**

ARHIP54616

Age

56Y
r
0Mt
h
7Days

Sex

Male

**Date
of
Admission**

04-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

HUSNABAD,Karimnaga
r,Telangana

**Ward
/Bed
No**

First
Floor,
MIC
U,
Bed
no:
MIC
U 4

**Primary
Consultant**

DR. NIKHIL GOLI --

STATUS EPILEPTICUS
? METABOLIC

History of seizures,
unresponsiveness since 1 day
Patient was recently admitted for encephalitis

Known case of diabetes mellitus on regular medication

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/90mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 80%

P/A: Soft

A 56 years old male patient Mr. K YELLAIAH came with history of seizures, unresponsiveness since 1 day. Patient was recently admitted for encephalitis. All necessary investigations were done and diagnosed as STATUS EPILEPTICUS
? METABOLIC . Managed conservatively. Patient referred to higher center for further management. Patient is being discharged with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. ENCORATE CHRONO 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 3) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 4) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 6) TAB. MULTIVITAMIN ONCE DAILY AT 2PM FOR 10 DAYS
- 7) DIABETIC ENSURE POWDER FOR RT

REVIEW AFTER 7 DAYS IN DR NIKHIL SIR OPD

ARH1.00012
03498

**Patient
Identifier**

ARHIP54675

Sex

Male

**Date of
Discharge
MLC No**

10-Feb-2022

**Na
me**

Mr. K RAJA
RAM

Age

66Yr
0Mth
26Days
08-
Feb-
2022

**Date of
Admission**

Address

GODAVARIKHANI,
PEDDAPALLY,Karimnagar,Telangana

Ward/Bed No

First Floor,
CICU ,
Bed no:CICU13

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

Surgeons

Anesthesiologists



Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

ADHF
SEVERE LV SYSTOLIC DYSFUNCTION EF;25%
RF;HTN,T2DM.

C/o shortness of breath on exertion since 1 week

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 66 years old male patient Mr. K RAJA RAM came with c/o shortness of breath on exertion since 1 week. All necessary investigations were done and diagnosed as ADHF, SEVERE LV SYSTOLIC DYSFUNCTION, EF;25%, RF;HTN,T2DM. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 10MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. LANOXIN 0.25 MG ONCE DAILY AT 2PM TO CONTINUE 5/7
4. TAB: CARDIVAS 3.125 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RECLIDE-MR 30 MG ONCE DAILY AT 2PM TO CONTINUE.

QUIT SMOKING AND ALCOHOL

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0
001176
441

Name

Mr.
SAL
LA
NA
MP
ALL
Y

Patient Identifier

ARHIP54465

Age

72Y
r
8Mt
h
11
Da
ys
24-
Jan-
202
2

Sex

Male

Date of Admission

Exp

25-Jan-2022

**Pri
ma
ry
Co
nsu
lta
nt
Sur
geo
ns**

CHEERLAVANCHA, SIRCILLA,
Karimnagar, Telangana

Dr Chandra Shekar
Sathineni(MD (Internal
Medicine))--INTERNAL
MEDICINE

Ward/
Bed No

Consultants

Anesthesiologists

Ground Floor, Emergency Ward, Bed no: EM E4

Diagnosi

Diagnosis

Disease	Disease Type
CAG DONE ADVISED CORONARY ARTERY BYPASS GRAFT. LOWER RESPIRATORY TRACT INFECTION WITH ACUTE KIDNEY INJURY	

ARH1.0001227
000

Patient Identifier

Sex

Expired Date
MLC No

Address

Primary

ARHIP54470

Male

27-Jan-2022

9-6-42, SAI
NAGAR,Sircilla,Telang
ana

Dr. Vidya Sagar A--

**Na
me**

Mr. PANI PAVAN

Age

Date of Admission

Ward/Bed No

Consultants

22Yr
0Mth
3Days
24-Jan-
2022

First
Floor,
MICU,
Bed
no:MIC
U 5

Consultant
Surgeons

CARDIOLOGY

Anesthesiologists

Diagnosis



Diagnosis

Disease	Disease Type
CARDIOGENIC SHOCK	Pd

C/o chest pain a/w SOB since 2-3 months

AT ADMISSION:

PR: 130/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 22 years old male patient Mr. PANI PAVAN came with c/o chest pain a/w SOB since 2-3 months. All necessary investigations were done and diagnosed as CARDIOGENIC SHOCK. Poor prognosis explained to the patient attendants. On 27.01.2021 at 5.10 AM patient got cardiac arrest. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. DC shock 200 J given, patient not responded. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.57 AM on 27/01/2022.

CAUSE OF DEATH

SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO CARDIOGENIC SHOCK

ARH1.0001227
516

**Na
me**

Mrs. B
VASANTH
A

**Patient
Identifier**

ARHIP54658

Age

55Yr
0Mth
5Days

Sex

Female

**Date of
Admission**

07-Feb-
2022

**Date of
Discharge
MLC No**

Address

ADAVISRIRAMPUR,
PEDDAPALLY,Karimnagar,Tela
ngana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U3

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CVA, LEFT HEMIPARESIS (04/08/2020)

CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-DVD (LAD, RCA)

PTCA+DES TO LAD WITH 3.0 X 19 MM METAFOR DONE ON 10/02/2022
R/F: HTN, T2DM

C/o chest pain a/w sweating, nausea and SOB since 5 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52years old female patient Mrs. B VASANTHA came with c/o chest pain a/w sweating, nausea and SOB since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CVA, LEFT HEMIPARESIS (04/08/2020), CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-DVD (LAD, RCA), PTCA+DES TO LAD WITH 3.0 X 19 MM METAFOR DONE ON 10/02/2022, R/F: HTN, T2DM, OLD CVA. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 70MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 20 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARDACE 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. IMDUR 30 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
- 8) INJ HUMAN MIXTURED 30/70 18 Units AT 8AM AND 12 Units AT 8PM CONTINUE
- 9) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54585

ARH1.00012273
20

Name

Mr.
MURALIDHA
R RAVULA

**Patient
Identifier**

ARHIP54585

Age

56Yr
0Mth
11Days

Sex

Male

**Date of
Admission**

02-
Feb-
2022

**Date of
Discharge
MLC No**

Address

ASIFABAD, KOMURAM
BHEEM,Tandur,Telanga
na

**Ward/Bed
No**

First
Floor,
CT
POST,
Bed
no:CT
1

**Primary
Consultant**

Dr SOMASHEKAR K(

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA]
DONE ON 08/02/2022.

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P AWTMI+SEVERE
LV DYSFUNCTION+ DM+HTN+HYPOTHYROIDISM

C/o chest pain a/w SOB since 3 days

K/c/o T2DM, HTN, Hypothyroidism

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 56 years old male patient Mr. MURALIDHAR RAVULA presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P AWMI+SEVERE LV DYSFUNCTION+ DM+HTN+HYPOTHYROIDISM, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 08/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED PARADOXICAL SEPTAL MOTION, MODERATE MR, MILD TR, EF-30%

BMI is 23 kg/m².

Sr. Creatinine report on 08.02.2022 1.2 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ELTROXIN 125MCG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) INJ HUMAN MIXTARD 20 U S/C AT 8AM, 15 U S/C AT 8PM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

9) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001
227521

Name

Mr.
ABBU
CHAV
USH
CHOU
SHA

**Patient
Identifier**

ARHIP54669

Age

79Yr
0Mth
4Days

Sex

Male

**Date
of
Admission**

08-
Feb-
2022

**Date
of
Discharge
MLC
No**

Address

11-10
LUXXEITPET,Karimnagar,
Telangana

**Ward
/Bed
No**

First
Floor
,
CICU
,
Bed
no:C
ICU1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, PULMONARY EDEMA
SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-25%

R/F: HTN, T2DM, SMOKING

CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 4.0 X 32 MM 3V ASTRA DONE ON 08/02/2022

C/o sudden onset of chest pain a/w sweating and SOB

AT ADMISSION:

Afebrile

PR: 74/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 79 years old male patient Mr. ABBU CHAVUSH CHOUSHHA came with c/o sudden onset of chest pain a/w sweating and SOB . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, PULMONARY EDEMA, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-25%, R/F: HTN, T2DM, SMOKING, CORONARY ANGIOGRAM DONE ON 08/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 4.0 X 32 MM 3V ASTRA DONE ON 08/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARDACE 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. LASIX 40 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) CAP. ABFLO 100 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. ALDACTONE 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 9) HOME NEBULIZATION

10) INJ HUMAN MIXTARD 30/70 24 U S/C AT 8AM, 12 U S/C AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS
ADVICE TO CONSULT PULMONOLOGIST

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54691 MALLAVVA 56

ATYPICAL CHEST PAIN
GLOBAL HYPOKINESIA
MILD MR, SR, SEVERE LV DYSFUNCTION [EF-30%]

R/F : TOBACCO ADDICTION

CORONARY ANGIOGRAM (12/02/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o chest pain since 2 days associated with shortness of breath

H/o chronic tobacco chewer

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 56 years old female patient MALLAVVA came with c/o chest pain since 2 days associated with shortness of breath. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, GLOBAL HYPOKINESIA, MILD MR, SR, SEVERE LV DYSFUNCTION [EF-30%], R/F : TOBACCO ADDICTION, CORONARY ANGIOGRAM (12/02/2022) -NORMAL

CORONARIES, ADV: MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 20MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDIVAS 3.125MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

54684 M LAXMI 55

CORONARY ARTERY DISEASE , AWTMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-55%

S/P CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-DVD

PLAN CABG.

R/F T2DM

C/o burning sensation of chest since 2 months associated with palpitations, sweatings and shortness of breath

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 55 years old female patient M. LAXMI came with c/o burning sensation of chest since 2 months associated with palpitations, sweatings and shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , AWTMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-55%, S/P CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-DVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. CLOPILET-A 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PROLOMET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. TRIVOLIB-2 TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001
227624

Name

Mr. P
KOMUR
AIAH

**Patient
Identifier**

ARHIP54706

Age

60Yr
0Mth
2Days

Sex

Male

**Date
of
Admission**

10-
Feb-
2022

**Date
of
Discharge
MLC
No**

Address

„Bejjanki, Telangana

**Ward/
Bed
No**

First
Floor,
MICU,
Bed no:
MICU 5

**Primary
Consultant**

Dr. Vidya
Sagar

CORONARY ARTERY DISEASE , ACUTE AAWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-DVD (LAD, RCA)

PLAN CABG.

R/F: HTN

C/o atypical chest pain radiating to back a/w neck pain since 1 day

K/c/o HTN

At Admission

Afebrile

PR: 86/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-100%

A 60 years old male patient Mr. KOMURIAH came with c/o atypical chest pain radiating to back a/w neck pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-DVD (LAD, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.000103
2401

**Na
me**

Mr.
SATYANARAYA
NA GADAPA

**Patient
Identifier**

ARHIP54698

Age

47Yr
2Mth
11Day
s

Sex

Male

**Date of
Admission**

10-
Feb-
2022

**Date of
Discharge
MLC No**

Address

8-5-54
VEMULAWADA,Karimnagar,
Andhra Pradesh

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U7

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 10/02/2022 - CAD-DVD (LAD, RCA)

S/P PTCA+DES TO LAD & RCA (2012)

PLAN CABG (2014)

S/P PTCA+DES TO RCA WITH 3.0 X 38 MM RESOLUTE ONYX DONE ON 10/02/2022
R/F: HTN, T2DM

C/o chest pain since 1 day

K/c/o HTN, T2DM

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 47 years old male patient Mr. SATYANARAYANA GADAPA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 10/02/2022 - CAD-DVD (LAD, RCA), S/P PTCA+DES TO LAD & RCA (2012), PLAN CABG (2014), S/P PTCA+DES TO RCA WITH 3.0 X 38 MM RESOLUTE ONYX DONE ON 10/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BTILLINTA 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012276
91

Name

Mr. A
PURUSHOTHAM

Patient Identifier

ARHIP54724

Age

64Yr
0Mth
2Days
13-Feb-
2022

Sex

Male

Date of Admission

Date of Discharge
MLC No

Address

GANGHI ROAD
KORUTLA ,Karimnagar,
Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
2

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CAD, UNSTABLE ANGINA, RBBB

NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%]

R/F : HTN

CORONARY ANGIOGRAM (13/02/2022) - Mild LAD diseased

PLAN MEDICAL MANAGEMENT

C/o chest pain since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 64 years old male patient Mr. A PURUSHOTHAM came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CAD, UNSTABLE ANGINA, RBBB, SR, NORMAL LV SYSTOLIC DYSFUNCTION [EF-60%], R/F : HTN, CORONARY ANGIOGRAM (13/02/2022) - Mild LAD diseased, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. METZOK 50MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1. 00011 76441	Name	Mr. SA LL A NA MP AL LY	
Patient Identifier	ARHIP54465	Age	72 Yr 8M th 11 Da ys
Sex	Male	Date of Admission	24 - Jan - 20 22

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No**

25-Jan-2022

**Ad
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CHEERLAVANCHA,SIRCILL
A,Karimnagar,Telangana

**Ward/
Bed
No**

Gr
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Dr Chandra Shekar
Sathineni(MD (Internal
Medicine))--INTERNAL
MEDICINE

**Consul
tants**

**Anest
hesiol
ogists**

Diagnosi
s

Diagnosis



Diseas e	Disease Type
-------------	-----------------

CAG DONE ADVISED CORONARY ARTERY BYPASS GRAFT. LOWER RESPIRATORY TRACT
INFECTION WITH ACUTE KIDNEY INJURY

C/o severe SOB a/w profuse sweating

k/c/o HTN, T2DM, CAD-TVD

AT ADMISSION:

Afebrile

PR: 99/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% with NIV support

P/A: Soft

A 72 yrs old male patient Mr. SALLA NAMPALLY came to hospital with c/o severe SOB a/w profuse sweating . All necessary investigations done and diagnosed as CAG DONE ADVISED CORONARY ARTERY BYPASS GRAFT. LOWER RESPIRATORY TRACT INFECTION WITH ACUTE KIDNEY INJURY. Managed conservatively. On dated 25/01/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 04.41 AM on 25/01/2022.

CAUSE OF DEATH

LOWER RESPIRATORY TRACT INFECTION WITH ACUTE KIDNEY INJURY

CAG DONE ADVISED CORONARY ARTERY BYPASS GRAFT.

ARH1.0001217
394

**Na
me**

Mr. S D SAYEED

**Patient
Identifier**

ARHIP53721

Age

57Yr
5Mth
6Day

S

Sex	Male	Date of Admission	23-Nov-2021
Expired Date	25-Nov-2021		
MLC No			
Address	73-177/4, 3 RD JONE MANCHERIAL 9502788746,Other	Ward/Bed No	
Primary Consultant	Dr. RAMCHANDER TORREM(MD (General Medicine),DM Nephrology(NIMS),Asso ciate Consultant- Nephrologist)-- NEPHROLOGY	Consultants	
Surgeons		Anesthesiologists	

It draft



Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
SEPTIC SHOCK, B/L LOWER LIMB CELLULITIS.	

C/o shortness of breath since 1 day

k/c/o HTN, T2DM, CAD

AT ADMISSION:

Afebrile

PR: 74/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 57 yrs old male patient Mr. SAYEED came to hospital with c/o shortness of breath since 1 day. All

necessary investigations done and diagnosed as SEPTIC SHOCK, B/L LOWER LIMB CELLULITIS. Managed conservatively. On 25/11/21 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 08.19 AM on 25/11/2021.

CAUSE OF DEATH: SEPTIC SHOCK, B/L LOWER LIMB CELLULITIS

53708 it draft

ARH1.0001226 898		Na me	Mr. DUMPALA BHOOMAI AH
Patient Identifier	ARHIP54662	Age	50Yr 5Mth 7Da ys
Sex	Male	Date of Admissi on	07- Feb- 202 2
Date of Discharge MLC No			
Address	6-72 JOGANPALLY KARIMNAGAR 9177092395 ,Koratla,Te langana	Ward/ Bed No	First Floor , CT POS T, Bed no:C T 2
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consul tant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM DONE
ON 09/02/2022.

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + HTN+DM S/P
AWMI+ MODERATE LV DYSFUNCTION+ PSORIASIS +RENAL DYSFUNCTION+?
OLD PULMONARY KOCH'S

C/o left sided chest pain since 1 day

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 50 years old male patient Mr. DUMPALA BHOOMIAH presented to hospital with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + HTN+DM S/P AWTMI+ MODERATE LV DYSFUNCTION+ PSORIASIS +RENAL DYSFUNCTION+? OLD PULMONARY KOCH'S, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] DONE ON 09/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, GRADE-III DIASTOLIC DYSFUNCTION, MILD MR,TR, PAH, EF-35%, NO PE/CLOT/VEG

BMI is 17 kg/m².

Sr. Creatinine report on 08.02.2022 1.3 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.

- 5) TAB. MET-XL 25MG TWICE DAILY AT 8AM PM TO CONTINUE.
- 6) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 11) TAB. METFORMIN 500 MG ONCE DAILY AT 7AM BBF TO CONTINUE

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.00012275
18

Name

Mr.
PRABHAKA
R YERRAM

**Patient
Identifier**

ARHIP54670

Age

44Yr
0Mth
7Days

Sex

Male

**Date of
Admission**

08-Feb-
2022

**Date of
Discharge
MLC No**

Address

H.NO:17-
38,MANCHIRAIL,Other,Ot
her

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
4

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-48%

S/P TLT WITH INJ. RETEPLASE (07/02/2022) OUTSIDE

CORONARY ANGIOGRAM DONE ON 11/02/2022 - CAD-SVD (LCX)

PTCA+DES TO OM WITH 3V ASTRA 3.0 X 20 MM DONE ON 11/02/2022
R/F: ALCOHOL, SMOKING

C/o gradual increased chest pain since 3 days radiating to back a/w
giddiness

AT ADMISSION:

Afebrile

PR: 104/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 44 years old male patient Mr. PRABHAKAR YERRAM came with c/o gradual increased chest pain since 3 days radiating to back a/w giddiness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-48%, S/P TLT WITH INJ. RETEPLASE (07/02/2022) OUTSIDE, CORONARY ANGIOGRAM DONE ON 11/02/2022 - CAD-SVD (LCX), PTCA+DES TO OM WITH 3V ASTRA 3.0 X 20 MM DONE ON 11/02/2022, R/F: ALCOHOL, SMOKING. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012 06469		Name	Mrs. WAJID UNNISA BEGUM
Patient Identifier	ARHIP54713	Age	79Yr 10Mth 30Days
Sex	Female	Date of Admission	11-Feb-2022
Date of Discharge MLC No			
Address	KARIMNAGAR,Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CHB, ACUTE IWMI, NO TLT, SR

NORMAL LV DIASTOLIC DYSFUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 11/02/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3V ASTRA 3.5 X 32 MM DONE ON 11/02/2022
TPI DONE ON 11/02/2022
R/F: HTN,T2DM

C/o SOB, b/l pedal edema since 1 day

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 79 years old female patient Mrs. WAJID UNNISA BEGUM came with c/o SOB, b/l pedal edema since 1 day. All necessary investigations were done and diagnosed as CHB, ACUTE IWMI, NO TLT, SR, NORMAL LV DIASTOLIC DYSFUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 11/02/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3V ASTRA 3.5 X 32 MM DONE ON 11/02/2022, TPI DONE ON 11/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. GLYCOMET SR 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

ORTHO CONSULTATION

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
27351

Name

Mr.
MOHAM
MAD
ABUUDH

**Patient
Identifier**

ARHIP54637

Age

59Y
r
2Mt
h
12D
ays

Sex

Male

**Date
of
Admission**

06-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

7-7-199,
MUKARAM PURA
JAGTIAL
8978669371,Tel
angana

**Ward/
Bed
No**

First
Floor,
CT
POST,
Bed
no:CT
5

**Primary
Consultant**

Dr
SOMASHEKAR K

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + MODERATE LV
DYSFUNCTION+ HTN+S/P AWM

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO
OM, PDA] DONE ON 10/02/2022.

C/o chest pain radiating to back since 6 days

K/c/o HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 59 years old male patient Mr. MOHAMMAD ABUUDH presented to hospital with c/o chest pain radiating to back since 6 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ DM+HTN+S/P AWTMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 10/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED LV RWMA, MODERATE LV DYSFUNCTION, GRADE-II DIASTOLIC DYSFUNCTION, MILD MR,TR, PAH, EF-40%, NO PE/CLOT/VEG.

BMI is 16 kg/m².

Sr. Creatinine report on 11.02.2022 1.2 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CORDARONE 200MG ONCE THRICE AT 8AM 2PM 8PM TO CONTINUE.
- 5) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

7) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

SATAMA CABG

RAJAIAH CABG

SUGUNA TURBT

ARH1.0001 227630		N a m e	Mr. KONDA ELLAIAH	
Patient Identifier	ARHIP54700		Age	53 Yr 0M th 1D ays
Sex	Male		Date of Admission	10- Feb - 20 22
Expired Date MLC No	11-Feb-2022			
Address	H.NO:3- 21/2,KALLEPALLY,BEJJANKI,SIDDIPET, Other,Telangana		Ward/Bed No	Firs t Flo or, HD U, Be d no: HD U 6
Primary Consulta nt	Dr. Vidya Sagar A--CARDIOLOGY		Consultan ts	
Surgeons			Anesthesi ologists	
		Diagnosi s		
Diagnosis				
Disease		Disease Type		
CAD ACUTE AWWMI,SEVERE LV SYSTOLIC				

DYSFUNCTION,EF;30%.

C/o chest pain a/w vomiting and sweating since 1 day

AT ADMISSION:

PR: 93/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 53 years old male patient Mr. KONDA ELLAIAH came with c/o chest pain a/w vomiting and sweating since 1 day. All necessary investigations were done and diagnosed as CAD ACUTE AWM, SEVERE LV SYSTOLIC DYSFUNCTION,EF;30%,INFERIOR WALL MI MODERATE LV DYSFUNCTION EF-35%. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 09.34 AM on 11/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CAD ACUTE AAWMI, SEVERE LV
SYSTOLIC DYSFUNCTION, EF: 30%.

ARH1.0001 227640	Name		Mr. GANGA DHAR RUTTA	
	Patient Identifier	ARHIP54711	Age	54Yr 0Mth 4Days
	Sex	Male	Date of Admission	11-Feb-2022
	Date of Discharge MLC No			
	Address	1-4-78/8 ADARSHA NAGAR,Karimnagar, Telangana	Ward/Bed No	First Floor , CICU , Bed no:CI CU8
	Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE, ACUTE AWM I

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD-PROXIMAL WITH 3V ASTRA 3.5 X 24 MM, LAD-MID WITH 3V
ASTRA 3.0 X 28 MM
DONE ON 12/02/2022

C/o Sudden retrosternal chest pain radiating to back and mild sweatings since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 54 years old male patient Mr. GANGADHAR RUTTA came with c/o Sudden retrosternal chest pain radiating to back and mild sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 12/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD-PROXIMAL WITH 3V ASTRA 3.5 X 24 MM, LAD-MID WITH 3V ASTRA 3.0 X 28 MM DONE ON 12/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 40 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARDACE 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) CAP. ABFLOW 100 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. MUSINAC 600 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001153
467

**Na
me**

Mrs. R PRAYGA

**Patient
Identifier**

ARHIP54632

Age

81Yr
10Mth
0Days

Sex

Female

**Date of
Admission**

05-
Feb-
2022

**Date of
Discharge
MLC No**

Address

MARKET
ROAD,Karimnagar,Telan
gana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MIC
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**Primary
Consultant
Surgeons**

DR. NIKHIL GOLI --
NEUROLOGY

**Consultants
Anesthesiolo
gists**

Diagnosi
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Diagnosis



Diseas e	Disease Type
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CEREBRAL VASCULAR ACCIDENT
ACUTE INFARCT IN LEFT MIDDLE CEREBRAL ARTERY TERRITORY
ATRIAL FIBRILATION WITH FAST VENTRICULAR RATE
CHRONIC MYELOID LEUKEMIA.

C/o loss of speech associated with altered sensorium
H/o Cranioplasty 2004

K/c/o HTN

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft, BS+

GCS -E3, V3, M2

A 81 years old female patient PRAYGA presented with c/o loss of speech associated with altered sensorium, h/o Cranioplasty 2004. All necessary investigations were done and diagnosed as CEREBRAL VASCULAR ACCIDENT, ACUTE INFARCT IN LEFT MIDDLE CEREBRAL ARTERY TERRITORY, ATRIAL FIBRILLATION WITH FAST VENTRICULAR RATE, CHRONIC MYELOID LEUKEMIA. Managed conservatively. Poor prognosis explained to patient attendants. On 14.02.2022 at 10.00 pm patient developed bradycardia and became unresponsive, immediately CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 11.00 PM on 05/02/2022

CAUSE OF DEATH

SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO CEREBRAL VASCULAR ACCIDENT
ACUTE INFARCT IN LEFT MIDDLE CEREBRAL ARTERY TERRITORY
ATRIAL FIBRILLATION WITH FAST VENTRICULAR RATE
CHRONIC MYELOID LEUKEMIA.

ARH1.0
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Name

Mrs.
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ARHIP54708

Age

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Sex

Female

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11-Feb-2022

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Dr. Vidya Sagar A--
CARDIOLOGY

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Dr. Vidya Sagar A--
CARDIOLOGY

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Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
CAD AWTMI,MODERATE LV SYSTOLIC DYSFUNCTION,EF;40%,S/P CAG DONE ON(11/2/22),CAD-TVD.	

C/o chest pain since 2 days

AT ADMISSION:

PR: 109/min

BP: 120/80 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 80 years old female patient Mrs. RAJESHWARI J came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CAD AAMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, S/P CAG DONE ON (11/02/22), CAD-TVD. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.15 PM on 11/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO CAD AAMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF;40%, S/P CAG DONE ON(11/2/22), CAD-TVD.

ARH1.000
1043806

**N
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Mr.
LAXMI
NARA
YANA

**Patient
Identifie
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ARHIP54734

Age

61Yr
6Mt
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29D
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Sex

Male

**Date
of
Admi
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14-
Feb-
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**Date of
Dischar
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MLC No**

Address

2-
86,MANWADA,BOINIPALLY,KARIMNA
GAR,Other,Andhra Pradesh

**War
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Bed
No**

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Bed
no:C
ICU
1

**Primary
Consult
ant**

Dr. Vidya Sagar A--CARDIOLOGY

METABOLIC ACIDOSIS
UNCONTROLLED SUGAR
ADHF
CAD -AWMI
PTCA+DES TO LAD WITH NEXGEN 3.0 X 37 MM DONE ON 27/07/2013

C/o SOB and sweating since 1 day

K/C/O HTN,T2DM

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 105/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 61 years old male patient Mr. LAXMI NARAYANA came with c/o SOB and sweating since 1 day. All necessary investigations were done and diagnosed as METABOLIC ACIDOSIS, UNCONTROLLED SUGAR ADHF, CAD -AWMI, PTCA+DES TO LAD WITH NEXGEN 3.0 X 37 MM DONE ON 27/07/2013. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 20MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RAMISTAR 1.25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6. TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
7. INJ. HUMAN INSULATARD 8U S/C TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 5 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.000
1227707

Name

Mr. APPALA
RAM
MURTHY

**Patient
Identifie
r**

ARHIP54735

Age

64Y
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1D
ays
14-
Feb
-
202
2

Sex

Male

Date of Admission

Date of Discharge
MLC No

14-Feb-2022

Address

8 INCLINE
COLONY,GODAVARIKHANI,Kari
mnagar,Telangana

Ward/
Bed No

First Floor, MIC U, Bed no: MIC U 8

Primary Consultant Surgeons

DR. NIKHIL GOLI --NEUROLOGY

Consultants
Anesthesiologists

Diagnosis

Diagnosi

1

Disease

Disease Type

POSTERIOR CIRCULATION STROKE.
OLD CVA 3 YEARS BACK

C/o Giddiness and vomiting associated with SOB

AT ADMISSION:

Afebrile

PR: 76/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 64 years old male patient Mr. APPALA RAM MURTHY came with c/o giddiness and vomiting associated with SOB. All necessary investigations were done and diagnosed as POSTERIOR CIRCULATION STROKE, OLD CVA 3 YEARS BACK. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

UROSEPSIS

C/o fever with chills, dribbling of urine since 5 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 62 years old male patient Mr. MOHAMMED GULAM JEELANI came with c/o fever with chills, dribbling of urine since 5 days. All necessary investigations were done and diagnosed as UROSEPSIS. Managed conservatively. Urologist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. CALPOL SOS
- 5) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

54741

ARH1.0001227 766		Na me	Mr. N SURYA BHAGAVA N
Patient Identifier	ARHIP54741	Age	49Yr 0Mth 2Days
Sex	Male	Date of Admissi on	15-Feb- 2022
Date of Discharge MLC No			
Address	JAGITYAL,Karimnagar,Telang ana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 3
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%

R/F: SMOKING

CORONARY ANGIOGRAM DONE ON 15/02/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 19 MM BIOMIME AURA DONE ON 15/02/2022

C/o left sided chest pain since 1 day

H/o chronic smoker

AT ADMISSION:

Afebrile

PR: 87/min

BP: 120/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 49 years old male patient Mr. N SURYA BHAGAVAN came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, R/F: SMOKING, CORONARY ANGIOGRAM DONE ON 15/02/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 19 MM BIOMIME AURA DONE ON 15/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. NEXITO 5MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. DILZEM SR 90MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012 27804		Name	Mr. MANDAL OJI PRABHA KAR
Patient Identifier	ARHIP54759	Age	54Yr 0Mth 1Days
Sex	Male	Date of Admission	16- Feb- 2022
Date of Discharge MLC No			
Address	5-69/1, ITIKYAL,JAGTIAL,Karimnagar, Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CIC U13
Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

SR, NORMAL LV FUNCTION [EF-60%]

R/F : HTN

CORONARY ANGIOGRAM (16/02/2022) -CAD-(Left dominant system) (LAD, LCX, RCA)

PLAN CABG WITH GRAFT TO MID LAD, DISTAL LAD, OM1 & OM3

C/o chest pain since 4 days, burning type, neck pain since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 88/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 54 years old male patient Mr. MANDALOJI PRABHAKAR came with c/o chest pain since 4 days, burning type, neck pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV FUNCTION [EF-60%], R/F : HTN, CORONARY ANGIOGRAM (16/02/2022) -CAD-(Left dominant system) (LAD, LCX, RCA), PLAN CABG WITH GRAFT TO MID LAD, DISTAL LAD, OM1 & OM3. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSUVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. BETOLOC 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RAMISTAR 1.25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6. TAB. MONIT GTN 2.6 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000 1227771		N a m e	Mr. MADA SU RAJAIA H	
Patient Identifier	ARHIP54745		Age	41Yr 1Mth 2Days
Sex	Male		Date of Admission	15- Feb- 2022
Date of Discharge MLC No				
Address	3-80, PALAKURTHY,PEDDAPALLI,Karimn agar,Telangana		Ward /Bed No	First Floor, CICU , Bed no:CI CU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

BRUGADA TYPE-I,

ATYPICAL CHEST PAIN

SR, NORMAL LV FUNCTION [EF-60%]

R/F : ALCOHOLIC

CORONARY ANGIOGRAM (17/02/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o Right sided chest pain a/w SOB, sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 41 years old male patient Mr. MADASU RAJAIAH came with c/o right sided chest pain a/w SOB, sweating since 1 day . All necessary investigations were done and diagnosed as BRUGADA TYPE-I, ATYPICAL CHEST PAIN, SR, NORMAL LV FUNCTION [EF-60%], R/F : ALCOHOLIC , CORONARY ANGIOGRAM (17/02/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

54743 RAMAIAH

CORONARY ARTERY DISEASE, NSTEMI

MODERATE LV DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (16/02/2022) -CAD-LM+TVD (LAD, LCX, RCA)

PLAN CABG WITH GRAFT TO LAD, DISTAL LCX, DISTAL RCA

C/o Sudden onset of retrosternal chest pain

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 79/min

BP: 140/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 56 years old female patient P RAMAIAH came with c/o retrosternal chest pain a/w SOB since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MODERATE LV

DYSFUNCTION [EF-40%]. CORONARY ANGIOGRAM (16/02/2022) -CAD-LM+TVD (LAD, LCX, RCA), PLAN CABG WITH GRAFT TO LAD, DISTAL LCX, DISTAL RCA. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

Cabg

Thirupathi pcnl

ARH1.0001 227782		N a m e	Mrs. BHAGYA MMA PUTTA	
Patient Identifier	ARHIP54752		Age	56Yr 0Mth 2Days
Sex	Female		Date of Admission	16- Feb- 2022
Date of Discharge MLC No				
Address	H.NO:3- 106,POTTUR,ELLANTHAKUNT A,RAJANNA SIRICILLA,Other,Other		Ward/ Bed No	First Floor, CICU , Bed no:CI CU10
Primary Consultant	Dr. Vidya Sagar A--			

ATYPICAL CHEST PAIN WITH ECG CHANGES, SR
NORMAL LV SYSTOLIC FUNCTION, EF -55%
HYPOTHYROID
CORONARY ANGIOGRAM (18/02/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

C/o Sudden onset of retrosternal chest pain

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 56 years old female patient Mrs. BHAGYAMMA PUTTA came with c/o Sudden onset of retrosternal chest pain. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES, SR, NORMAL LV SYSTOLIC FUNCTION, EF -55%, HYPOTHYROID, CORONARY ANGIOGRAM (18/02/2022)-NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. THYRONORM 50MCG ONCE DAILY AT 7AM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000122758 4	ARHIP547 23	Mrs. MANEPELLI LAXMI Female 55Yr 0Mth 9Days
---------------------	--	--

LMCA CRITICAL LESION AND RCA CRITICAL LESION + DM+ HTN+ S/P AWM

SURGERY - EMERGENCY CORONARY ARTERY BYPASS GRAFTING SVG to LAD,
OM, dRCA DONE ON 14/02/2022.

C/o chest pain a/w SOB since 3 days

K/c/o T2DM, HTN,

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 55 years old female patient Mrs. MANEPELLI LAXMI presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as LMCA CRITICAL LESION AND RCA CRITICAL LESION + DM+

HTN+ S/P AAMI, SURGERY - EMERGENCY CORONARY ARTERY BYPASS GRAFTING SVG to LAD, OM, dRCA DONE ON 14/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS __

BMI is __ kg/m².

Sr. Creatinine report on 15.02.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. MET XL 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. DIXIN 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.
- 8) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 10) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001
227556

Name

Mrs.
GADAMA
NDLA
RATHNA
MMA

**Patient
Identifier**

ARHIP54719

Age

93Y
r
2Mth
10Days

Sex

Female

**Date
of
Admission**

12-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

3-1-234 CHRISTIAN
COLONY,Karimnagar
,Telangana

**Ward
/Bed
No**

First
Floor,
MIC
U,
Bed
no:
MIC
U
12

**Primary
Consultant**

DR. SRI KARAN
UDDESH

SYMPTOMATIC HYPONATRAEMIA
AKI (RESOLVING)
UTI ASSOCIATED SEPSIS
NCNC ANAEMIA

C/o altered sensorium, slurring of speech

H/o Vomiting 2 episodes, Irrelevant talk , constipation

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 119/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 93% on 2Litr O2

P/A: Soft

A 93 years old female patient RATHNAMMA presented with the above-mentioned complaints patient was treated with 3% NACL infusion for symptomatic hyponatraemia. Patient was started on INJ.CEFTAZIDIME-TAZOBACTAM in view of urinary tract infection. CT brain was done which was normal. An ENT consultation was done as patient had difficulty in swallowing, only nasal endoscopy could be done as patient was not cooperative for laryngoscopy. Advised CT neck but attenders are unwilling since hence CT neck not done. Patient was initially on oxygen support about 10 L/min. Now the patient is of oxygen support is 93% stable on room air. Now the patient's attenders want discharge. Hence patient is being discharged against medical advice, risks have been explained.

ARH1.0001
227815

Name

Mrs.
TEJK
ORE .

**Patient
Identifier**

ARHIP54756

Age

42Yr
0Mth
3Days

Sex

Female

**Date
of
Admission**

16-
Feb-
2022

**Date
of
Discharge
MLC
No**

Address

TIPPAPURAM,Sircilla,T
elangana

**Ward/
Bed
No**

First
Floor
,
CICU
, Bed
no:CI
CU8

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION (EF-40%)

CORONARY ANGIOGRAM DONE ON 16/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 16/02/2022
R/F: T2DM

VIRAL PYREXIA

C/o chest pain since 1 day

K/C/O T2DM

AT ADMISSION:

Afebrile

PR: 100/min

BP: 120/70 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 92% on room air

P/A: Soft

A 42 years old female patient Mrs. TEJKORE came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION (EF-40%), CORONARY ANGIOGRAM DONE ON 16/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 16/02/2022, R/F: T2DM, VIRAL PYREXIA. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE AFTER LUNCH.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. GLYCOMET GP1 500MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
227622

Name

Mrs.
BANT
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SWAP
ANA

**Patie
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Ident
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ARHIP54733

Age

30Yr
11M
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9Da
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Sex

Female

**Date
of
Admi
ssion**

14-
Feb-
202
2

**Date
of
Disch
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MLC
No**

**Addr
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15-3-457, L B NAGAR
PEDDAPALLI,Karimnaga
r,Telangana

**Ward
/Bed
No**

First
Floor
/
CICU
/
Bed
no:C
ICU9

**Prim
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Dr. Vidya Sagar A--
CARDIOLOGY

ACHD, OSTIUM SECUNDUM ASD (15 mm) L-R, SR

MILD TR, PAH

NORMAL LV SYSTOLIC DYSFUNCTION,

ASD CLOSURE (18 MM COCOON SEPTAL OCCLUDER) DONE ON 17/02/2022

C/o left sided chest pain

H/o blunt injury chest

AT ADMISSION:

Afebrile

PR: 78/min

BP: 100/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 30 years old female patient Mrs. BANTU SWAPANA came with c/o left sided chest pain, h/o blunt injury chest. All necessary investigations were done and diagnosed as ACHD, OSTIUM SECUNDUM ASD (15 mm) L-R, SR, MILD TR, PAH, NORMAL LV SYSTOLIC DYSFUNCTION, ASD CLOSURE (18 MM COCOON SEPTAL OCCLUDER) DONE ON 17/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. FOLVITE 5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. AUTRIN ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001227 776		Na me	Mr. MALLESHAM EMMADISHET TY	
Patient Identifier	ARHIP54747		Age	46Yr 0Mth 4Days
Sex	Male		Date of Admission	16-Feb- 2022
Date of Discharge MLC No				
Address	H.NO:5- 47,CHANDRAMPET,RAJAN NNA SIRICILLA,Other,Telangan a		Ward/Bed No	First Floor, CICU , Bed no:CIC U7
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 17/02/2022 - CAD-SVD (RAMUS)

PTCA+DES TO RAMUS WITH 2.5 X 24 MM METAFOR DONE ON 17/02/2022
R/F: HTN

C/o chest pain radiating to back a/w sweating since 2 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. MALLESHAM EMMADISHETTY came with c/o chest pain radiating to back a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 17/02/2022 – CAD-SVD (RAMUS), PTCA+DES TO RAMUS WITH 2.5 X 24 MM METAFOR DONE ON 17/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. BETALOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00
012276
94

Name

Mrs.
KAIR
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ARHIP54726

Age

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Sex

Female

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H.NO:3-2,
POTLAPALLY,HUSNABAD,SIDD
IPET,Other,Telangana

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Bed
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Dr. Iftekarali (MS
(Orthopaedics)

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY : CEMENTED BIPOLAR HEMIARTHROPLASTY LEFT HIP DONE ON 15/02/2022

Alleged to have sustained injury due to slip and fall at home on 13-02-2022

C/o pain and swelling in left hip.

K/C/O-HTN .

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-100/min

BP-140/100mmhg

RR-24/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-98%

A 73 years old female patient Mrs. KAIRUNNISA came with alleged history of sustained injury due to slip and fall at home on 13-02-2022, c/o

pain and swelling in left hip. All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY : COMMUNUTED BIPOLAR HEMIARTHROPLASTY LEFT HIP DONE ON 15/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

-
1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 2. TAB: METROGYL 400MG THRICE IN A DAY AT 8AM, 2PM, 8PM FOR 7 DAYS
 3. TAB. AMLODIPINE 5 MG ONE DAILY AT 8AM TO CONTINUE
 4. TAB. TAZOLAC CT 40/125 MG ONE DAILY AT 8AM TO CONTINUE
 5. TAB. VOVERAN SR 75MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 6. TAB. RANTAC TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO ORTHO SURGEON OPD.

ARH1.0001227 670		Name	Mr. SUDHAKAR BATHULA
Patient Identifier	ARHIP54716	Age	37Yr 0Mth 8Days
Sex	Male	Date of Admission	12-Feb-2022
Date of Discharge			
MLC No			
Address	5-51/21 SAIDPUR,Karimnagar,Telangan	Ward/Bed No	First Floor, CICU , Bed no:CICU 13
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

..

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT,
SR,SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
AKI, CONTRAST INDUCED NEPHROPATHY (SR.Cr.5.4MG/DL)
CVA, ACUTE INFARCT IN B/L MCA
CORONARY ANGIOGRAM DONE ON 15/02/2022 - CAD-TVD (LAD, LCX, RCA)
PTCA+DES TO LAD WITH 3.0 X 32 MM 3V ASTRA, OM WITH 2.5 X 16 MM METAFOR DONE ON
15/02/2022
R/F: T2DM, HTN

C/o sudden onset retrosternal chest pain, radiating to back a/w mild sweating
since 2 days

K/C/O T2DM, HTN

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96% on room air

P/A: Soft

A 37 years old male patient Mr. SUDHAKAR came with c/o sudden onset retrosternal chest pain, radiating to back a/w mild sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30% AKI, CONTRAST INDUCED NEPHROPATHY (SR.Cr.5.4MG/DL), CVA, ACUTE INFARCT IN B/L MCA, CORONARY ANGIOGRAM DONE ON 15/02/2022 - CAD-TVD (LAD, LCX, RCA), PTCA+DES TO LAD WITH 3.0 X 32 MM 3V ASTRA, OM WITH 2.5 X 16 MM METAFOR DONE ON 15/02/2022, R/F: T2DM, HTN. Neurologist and Nephrologist consultations taken and advice followed . Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-
- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
 - 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
 - 4) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 5) TAB. BETALOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 6) TAB. LASIX 40MG TWICE DAILY AT 8AM AND 4PM TO CONTINUE.
 - 7) TAB. ALDACTON 25 MG ONCE DAILY AT 9AM TO CONTINUE.
 - 8) SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM
 - 9) TAB. ALDACTON 25 MG ONCE DAILY AT 9AM TO CONTINUE.
 - 10) TAB. GLYCOMET GP 500 MG ONCE DAILY AT 8AM TO CONTINUE.
 - 11) TAB. ALCYSTA THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
 - 12) TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 13) TAB. KETOCHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 14) TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 15) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

REVIEW IN NEPHROLOGY OPD, NEUROPHYSICIAN OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54767 64

ARH1.00012278 24		Name	Mr. NARAYAN MALLAYYA TALAPELLI
Patient Identifier	ARHIP54767	Age	64Yr 1Mth 18Days
Sex	Male	Date of Admission	17-Feb-2022
Date of Discharge MLC No			
Address	H NO-2-29,HARIDAS NAGAR,YELLA REDDYPET MDL,Sircilla,Telangan a	Ward/ Bed No	First Floor, MICU, Bed no:MIC U 4
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL MEDICINE		

GALLSTONE INDUCED ACUTE PANCREATITIS
COPD
HYPERTENSION

C/o paraumbilical pain radiating to the back associated with multiple episodes of vomiting since 16/02/2022 afternoon
H/o SOB grade-3 since 16/02/2022
Patient initially received treatment elsewhere and came here for further management

Known case of hypertension

AT ADMISSION:
Pt conscious, coherent
Afebrile
PR: 86/min
BP: 110/70mmHg
RS: BAE+, b/l crackles (fine Rt>Lt)
CVS: S1S2
RR: 18/min
SPO2: 80% on room air
P/A: Tenderness to superficial palpation in a in epigastric region

A 64-year-old male patient Mr. NARAYAN MALLAYYA TALAPELLI presented with the above-mentioned complaints who is a known case of hypertension and COPD. Patient had a history of community acquired pneumonia 3 months ago. Patient was admitted and evaluated thoroughly, on investigation Sr. LIPASE was elevated, CT abdomen revealed ACUTE PANCREATITIS, GALLSTONES, DILATED CBD WITH IHBD. Patient diagnosed as gallstone induced acute pancreatitis, acute type II respiratory failure. During the course in the hospital patient was managed with antiemetics, antacids, anticoagulants and antibiotics. As patient was not maintaining the saturation he was put on minimal oxygen support 4-2 Ltr of O2 support. In view of CBD dilatation MRCP was done which revealed Cholelithiasis with biliary sludge, Dilated CBD cystic duct common hepatic duct right leg, left hepatic ducts and intrahepatic biliary radicals ---? due to spasm of sphincter of Oddi, for which general Surgeon consultation was taken and Lap cholecystectomy was planned. Patient attendants are unwilling. Hence, patient is being discharged with medications and to be further followed with general surgeon.

DISCHARGE MEDICATION:

1. TAB. CIPLOX 250 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. SEROFLO INHALER 250 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. PAN 40 MG ONCE AT 7AM BBF FOR 7 DAYS
4. TAB. THIAMINE 100 MG ONCE DAILY AT 8AM FOR 7 DAYS
5. TAB. MONTEK LC ONCE DAILY AT 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE.

ARH1.0
001227
703

Name

Mrs
.GU
DA
LA
JAY
ALA
XMI

Patient Identifier

ARHIP54727

Age

63
Yr
0M
th
6D
ays
13
-
Feb
-
2022

Sex

Female

Date of Admission

Date of Discharge
MLC No
Address

H.NO:14-2-
68,PARASHURAMNAGAR,GODHAVARIKHA
NI,PEDDAPALLY,Other,Telangana

Ward/Bed No

Second Floor,
Female General Ward

**Pri
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DR. SANJAY KUMAR KAMINWAR

ACUTE INFARCT IN RIGHT ACA TERRITORY

C/o Sudden onset of left sided weakness

H/o Old CVA 3 episodes 2018 on regular medication
Seizures 8 years back

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 63 years old female patient Mrs. GUDALA JAYALAXMI came with c/o sudden onset of left sided weakness, h/o Old CVA 3 episodes 2018 on regular medication, Seizures 8 years back. All necessary investigations were done and diagnosed as ACUTE INFARCT IN RIGHT ACA TERRITORY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB: COLTRO 10MG ONCE DAILY AT 8PM FOR 11DAYS.
2. TAB. PREVA AS 75MG ONCE DAILY AT 2PM FOR 11DAYS.

REVIEW AFTER 11DAYS IN DR. SANJAYKUMAR sir OPD.

ARH1.00012278 43	ARHIP547 73	Mr. BURLA VENKATESHAM Male 52Yr 0Mth 2Days
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CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MILD LV DYSFUNCTION

CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021
R/F: DM

C/o chest pain a/w sweating, nausea and SOB since 1 day

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 52 years old male patient Mr. BURLA VENKATESHAM came with c/o chest pain a/w sweating, nausea and SOB since 1 day. All necessary investigations were done and diagnosed as

CORONARY ARTERY DISEASE, ACUTE AWMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 -

CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenosis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient **is being discharged in hemodynamically stable condition with required medication and advice.**

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

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Name

Mr.
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ARHIP54770

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Dr. SURESH GOUD

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S(MS,M.Ch
Urology(SVIMS),Consult
ant Urologist)--
UROLOGY

BLADDER CLOT

SURGERY: BLADDER CLOT EVACUATION DONE ON 17.02.2022

C/o hematuria

K/c/o HTN, T2DM

ON ADMISSION

Pt c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

A 81 yr old male patient Mr. KATIKI REDDY RAM CHANDRAIAH came with c/o hematuria. All necessary investigations were done and diagnosed as BLADDER CLOT, SURGERY: BLADDER CLOT EVACUATION DONE ON 17.02.2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE-CV 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS

Review after 11 days to urologist OPD.

ARH1.00012274
87

Name

Mr. PADAM
LINGANNA

**Patient
Identifier**

ARHIP54660

Age

55Yr
1Mth
14Days

Sex

Male

**Date of
Admission**

07-
Feb-
2022

**Date of
Discharge
MLC No**

Address

6-1-231/3,
KANDLAPALLY ROAD
JAGTIAL
8897365515,Telang
ana

**Ward/
Bed No**

First
Floor,
CT
POST,
Bed
no:CT
4

**Primary
Consultant**

Dr SOMASHEKAR

CRHD WITH SEVERE AS, CONCENTRIC LVH, MILD TR

Surgery: AVR WITH ST NO 21MM WITH MECHANICAL VALVE DONE ON 16/02/2022.

C/o SOB on exertion since 7 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old male patient Mr. PADAM LINGANNA came with c/o SOB on exertion since 7 days. All necessary investigations were done and diagnosed as CRHD WITH SEVERE AS, CONCENTRIC LVH, MILD TR, **Surgery:** AVR WITH ST NO 21MM WITH MECHANICAL VALVE DONE ON 16/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, NORMAL FUNCTIONING PROSTHETIC MV, NO VALVULAR/PARAVALVULAR LEAK, NO LV RWMA, MILD MR/TR/AR/PAH . NO PE/CLOT/VEG. EF-60%

BMI is 20.7 kg/m².

Sr. Creatinine report done on 17.02.2022 1.3 mg/dl

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 1MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE LIFE LONG
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. MET-XL 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
- 4) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
- 7) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

Mrs. SATAYMMA AKULA

**Patient
Identifier**

ARHIP54666

Age

58Yr

IT PROBLEM

CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+MILD LV DYSFUNCTION+S/P
AWMI+DIABITIS MELLITUS,HYPERTENSION. CORONARY ARTERY BYPASS GRAFTING LIMA TO
LAD,SVG TO OM + IABP.

C/o chest pain since 3 days

AT ADMISSION:

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 58 years old female patient Mrs. SATAYMMA AKULA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+MILD LV DYSFUNCTION+S/P AWMI+DIABITIS MELLITUS,HYPERTENSION. CORONARY ARTERY BYPASS GRAFTING LIMA TO LAD,SVG TO OM + IABP. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.46 AM on 18/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+MILD LV DYSFUNCTION+S/P AWTMI+DIABETIS MELLITUS,HYPERTENSION. CORONARY ARTERY BYPASS GRAFTING LIMA TO LAD,SVG TO OM + IABP.

ARH1.0001227
843

**Na
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Mr. BURLA
VENKATESHA
M

**Patient
Identifier**

ARHIP54773

Age

52Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

17-Feb-
2022

**Date of
Discharge
MLC No**

Address

VIDYANAGAR,Sircilla,Telan
gana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
12

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMi, NO TLT, SR

MILD LV DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 17/02/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.5 X 32 MM METAFOR DONE ON 17/02/2022
R/F: T2DM

C/o chest pain, nausea and SOB, sweating since 2 days

AT ADMISSION:

Afebrile

PR: 72/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on room air

P/A: Soft

A 52years old male patient Mr. BURLA VENKATESHAM came with c/o chest pain, nausea and SOB, sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 17/02/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.5 X 32 MM METAFOR DONE ON 17/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ZOMALIS MET 50 / 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001227
197

**Na
me**

Mr. E
MALLESHA
M

**Patient
Identifier**

ARHIP54545

Age

60Yr
0Mth
23Days

Sex

Male

**Date of
Admission**

29-
Jan-
2022

**Date of
Discharge
MLC No**

Address

PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no: SIC
U 1

**Primary
Consultant**

DR. SUBRAT KUMAR SOREN

LEFT CAPSULO-GANGLIONIC BLEED WITH MASS EFFECT

SURGERY : LEFT FTP DECOMPRESSIVE CRANIECTOMY DONE ON 29/01/2022.

C/o altered sensorium since today morning 6 AM on 29/01/2022 associated with slurring of speech

History of giddiness fall at home since 29/01/2022

Known case of type II DM on irregular medication

status post-right upper limb amputation 20 years ago

AT ADMISSION:

patient was drowsy responding to type pain stimulus

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 90%

P/A: Soft, BS+

Treated with

Inj Pan

Inj PCM

Inj LEVIPIL

Inj TONACT

Inj DUPHALAC

Syp POTKLOR

Inj LACOSAMIDE

Inj MEROPENUM

Inj LASIX

Inj ATROPINE

A 60 yrs old Mr Mallesham patient presented with c/o altered sensorium since today morning 6 AM on 29/01/2022 associated with slurring of speech, History of giddiness fall at home since 29/01/2022, Known case of type type II DM on irregular medication, status post-right upper limb amputation 20 years ago . Patient was admitted and evaluated thoroughly and on MRI brain patient was diagnosed to have intraparenchymal bleed in left capsuloganglionic region . Left fronto-parietal deep brain decompression craniectomy was planned and done on 29/01/2022 during the procedure patient was intubated and connected to mechanical ventilator. On 01/02/2022 at 7 AM patient had a history of seizures generalised tonic clonic and a hypotensive shock. The patient was resuscitated on ionotropes and VC/AC mode. During the course patient had fever spikes 100 F, tracheostomy was planned and done on 02/02/2022 at 5 p.m. Later Patient developed thick secretions diagnosed to have nosocomial pneumonia antibiotics were escalated. On 07/02/2022 T-piece trial

with thermovent was done which was uneventful and patient was maintaining saturations at room air, Sr.Electrolytes and ABG was monitored . Elective percutaneous tracheostomy done on 02.02.2022 in view of prolonged ventilator support. Patient is haemodynamically stable off ventilator support maintaining saturations. Patient condition explained to patient attenders and has been referred to neuro-rehabilitation Centre at request

DISCHARGE MEDICATION:

-
1. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
 2. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
 3. SYP. DUPHALAC 15 ML 15 ml ONCE DAILY AT 8PM TO CONTINUE
 4. TAB. TONACT 40 MG ONCE DAILY AT 8AM TO CONTINUE
 - 5.NEB WITH DUOLIN QID
 - 6.NEB WITH BUDECORD TID
 7. TAB. PERINORM 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
 8. TAB. REJUNEX ONCE DAILY AT 8AM TO CONTINUE
 9. TAB. STROCIT 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
 10. TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE
 11. TAB. FARONEM 250 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE

C/o headache since 6 months a/w giddiness, aphasia

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-84/min

BP-140/70mmhg

RR-14/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 35 years old female patient B.SARITHA presented to hospital with c/o headache since 6 months a/w giddiness, aphasia. All necessary investigations were done and diagnosed as LEFT LATERAL WING SPHENOID HEMANGIOMA,

LEFT TEMPORO PARIETAL CRANIECTOMY + EXCISION OF SOL done on 03/02/2021. Post operative period was uneventful. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. AUGMENTIN 650 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 2) TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. LEVIPIL 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. EPTOIN 100 MG THRICE DAILY AT 8AM 2 PM AND 8PM TO CONTINUE.
- 5) TAB. PAN 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 11 DAYS.
- 6) TAB. DEXONA 4 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
- 7) TAB. COLINIZA TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO NEUROSURGERY OPD

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Dr. Vidya Sagar A

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Name

Mrs.
SHAJAHAN
BEGUM

**Patient
Identifier**

ARHIP54774

Age

45Yr
0Mth
4Days

Sex

Female

**Date of
Admission**

17-Feb-
2022

**Date of
Discharge
MLC No**

Address

8 INC COLONY
GODAVARIKHANI
RAMAGUNDAM
PEDDAPALLI ,Karimn
agar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
3

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, NSTEMI

S/P TLT WITH INJ ELAXIM (17/02/2022)

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%

R/F: T2DM

CORONARY ANGIOGRAM DONE ON 19/02/2022 - CAD-DVD (LAD & RCA)

PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION, RCA WITH 2.5 X 18 MM
XIENCE XPEDITION DONE ON 19/02/2022

C/o sudden onset chest pain a/w sweating

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 45years old female patient Mrs. SHAJAHAN BEGUM came with c/o sudden onset chest pain a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, S/P TLT WITH INJ ELAXIM (17/02/2022), SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-45%, R/F: T2DM, CORONARY ANGIOGRAM DONE ON 19/02/2022 - CAD-DVD (LAD & RCA), PTCA+DES TO LAD WITH 3.5 X 28 MM XIENCE XPEDITION, RCA WITH 2.5 X 18 MM XIENCE XPEDITION DONE ON 19/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. GLYCOMET-GP1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000
1227940

Name

Mrs.
S
SATH
AVVA

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ARHIP54809

Age

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MUTHYAMPET,JAGITYAL,Karim
nagar,Telangana

**War
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Bed
No**

First
Floor,
Day
Care,
Bed
no:DC 2

**Prim
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Cons
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Dr. Vidya Sagar A

ATYPICAL CHEST PAIN

MILD MR, SEVERE PAH, SR

SEVERE LV DYSFUNCTION [EF-30%]

CORONARY ARTERY DISEASE, AWM

S/P PRIMARY PTCA+DES TO LAD 26/05/2019

CORONARY ANGIOGRAM (21/02/2022) -CAD-PATENT STENT IN PROXIMAL
LAD

PLAN MEDICAL MANAGEMENT

R/F: T2DM, HTN, OBESITY

C/o Retrosternal chest pain, neck pain, SOB since 3 days

K/C/O T2DM, HTN, OBESITY

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 67 years old female patient Mrs. S SATHAVVA came with c/o retrosternal chest pain, neck pain, SOB since 3 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, MILD MR, SEVERE PAH, SR, SEVERE LV DYSFUNCTION [EF-30%], CORONARY ARTERY DISEASE, AWTMI, S/P PRIMARY PTCA+DES TO LAD 26/05/2019, CORONARY ANGIOGRAM (21/02/2022) -CAD-PATENT STENT IN PROXIMAL LAD, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. CAP. ROSEDAY GOLD 10 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PROLOMET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.

3. TAB. RAMISTAR 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: DYTOR PLUS 10 MG ONCE DAILY AT 2PM TO CONTINUE.
5. CONTINUE OWN DIABETIC MEDICATION

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001
227925

**N
a
m
e**

Mr.
RAJAIA
H
MOLIG
E

**Patient
Identifie
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ARHIP54804

Age

55Y
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Sex

Male

**Date
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Admi
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20-
Feb
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202
2

**Date of
Discharg
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MLC No**

Address

H.NO:1-
23,GOPALRAOPALLY,THANGALLAP
ALLI,RAJANNA
SIRICILLA,Other,Telangana

**Ward
/Bed
No**

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**Primary
Consulta
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Dr. Vidya Sagar A--CARDIOLOGY

ACS – ADHF – CARDIOGENIC SHOCK

PULMONARY TB ON ATT 6 MONTHS BACK

R/F T2DM, HTN

C/o chest pain radiating to back since 1 day

H/o Pulmonary TB on ATT 6 months back

K/C/O T2DM, HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. RAJIAH MOLIGE came with c/o chest pain radiating to back since 1 day, h/o Pulmonary TB on ATT 6 months back. K/C/O T2DM, HTN. All necessary investigations were done and diagnosed as ACS – ADHF – CARDIOGENIC SHOCK, PULMONARY TB ON ATT 6 MONTHS BACK. Managed conservatively . Patient is referred to higher center for further management.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.000122 7760		Na me	Mr. ABDUL ARIF SHARIF	..
Patient Identifier	ARHIP54806		Age	42Yr 0Mth 7Days
Sex	Male		Date of Admis sion	20- Feb- 2022
Date of Discharge MLC No				
Address	GODAVARIKANI,PEDDAPALLI,Karimnagar, Telangana		Ward/ Bed No	First Floor, SICU, Bed no:SI CU 2
Primary Consultant	Dr. GOUTHAM ROY			

LEFT INGUINAL INDIRECT COMPLETE HERNIA

SURGERY: LEFT LAPAROSCOPIC INGUINAL TRANSABDOMINAL PREPERITONEAL
MESH REPAIR
DONE ON 21-02-22

C/o pain in left inguinal region since 1month.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 42yr old male Mr. ABDUL ARIF SHARIF came with c/o pain in left inguinal region since 1month. All necessary investigations done and diagnosed as LEFT INGUINAL INDIRECT COMPLETE HERNIA,
SURGERY: LEFT LAPAROSCOPIC INGUINAL TRANSABDOMINAL PREPERITONEAL MESH REPAIR

DONE ON 21-02-22. Findings: Complete herniation of omentum till root of scrotum noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

SCROTAL SUPPORT

Review after 10 days in General Surgery OPD.

ARH1.00012
27914

**Na
me**

Mr.
KISHTAI
AH PULI

**Patient
Identifier**

ARHIP54799

Age

61Yr
6Mth
12Da
ys

Sex

Male

**Date
of
Admis
sion**

20-
Feb-
2022

**Date of
Discharge
MLC No**

Address

JYOTHI
NAGAR, NTPC, Ramagundam,
Telangana

**Ward/
Bed
No**

First
Floor
,
MICU
, Bed
no: MI
CU 7

**Primary
Consultan
t**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

NORMAL LV/RV FUNCTION [EF-60%]

R/F: T2DM

CORONARY ANGIOGRAM (21/01/2022) -CAD-Mild disease RCA, LAD
myocardial bridging

PLAN MEDICAL MANAGEMENT

C/o generalised weakness mild chest pain associated with mild sweating, SOB since
1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old male patient Mr. KISHTAIAH PULI came with c/o generalised weakness mild chest pain associated with mild sweating, SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV/RV FUNCTION [EF-60%], R/F: T2DM, CORONARY ANGIOGRAM (21/01/2022) -CAD-Mild disease RCA, LAD myocardial bridging, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: NEBISTAR 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
6. TAB. JAUNAMET 50/100 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS reports

ARH1.00012267
86

Name

Mr.
ANJIAH
CH

**Patient
Identifier**

ARHIP54653

Age

42Yr
1Mth
3Days

Sex

Male

**Date of
Admission**

07-
Feb-
2022

**Date of
Discharge
MLC No**

Address

KOTHAKOMMUGUDEM,
LAXETTIPET,
MANCHERIAL,Tandur,Telanga
na

**Ward/
Bed No**

First
Floor,
CT
POST,
Bed
no:CT
6

**Primary
Consultant**

Dr SOMASHEKAR

MVP WITH SEVERE MR WITH LV DYSFUNCTION

Surgery: MVR WITH SJ NO. 29 mm, MECHANICAL VALVE DONE ON 17/02/2022

C/o SOB on exertion a/w palpitations since 7 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mr. ANJIAH CH came with c/o SOB on exertion a/w palpitations since 7 days. All necessary investigations were done and diagnosed as MVP WITH SEVERE MR WITH LV DYSFUNCTION, Surgery: MVR WITH SJ NO. 29 mm MECHANICAL VALVE DONE ON 17/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, he is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, GLOBAL HYPOKINESIA OF LV, MODERATE LV DYSFUNCTION, NO CLOT/PE/VEG, EF 38%

BMI is 19 kg/m².

Sr. Creatinine report done on 18.02.2022 1.1 mg/dl

DISCHARGE MEDICATION:

1) TAB. ACITROM 1MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE LIFE LONG

2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.

4) TAB. MET-XL 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.

5) TAB. DIXIN 0.25 MG ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. ROXSAFE 500+125 MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.

7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS.

8) SYP. CREMAFFIN 15 ml ONCE DAILY AT 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS.

ARH1.00012
27779

Name

Mr.
ANJA
IAH
KAD
ARI

Patient Identifier

ARHIP54749

Age

49Yr
0Mth
7Days

Sex

Male

Date of Admission

16-Feb-2022

**Date of Discharge
MLC No**

Address

4-17
ASIFNAGAR, Karimnagar,
Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CI
CU11

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 17/02/2022 - CAD-DVD (LCX, RCA)

PTCA+DES TO MID RCA WITH 2.75 X 40 MM METAFOR, PROXIMAL RCA WITH 3.0 X 13 MM METAFOR DONE ON 19/02/2022

MEDICAL MANAGEMENT FOR MAJOR OM (CTO)

C/o Retrosternal chest pain radiating to back since 2 days

AT ADMISSION:

Afebrile

PR: 60/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 49 years old male patient Mr. ANJIAH came with c/o retrosternal chest pain radiating to back since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 17/02/2022 - CAD-DVD (LCX, RCA), PTCA+DES TO MID RCA WITH 2.75 X 40 MM METAFOR, PROXIMAL RCA WITH 3.0 X 13 MM METAFOR DONE ON 19/02/2022, MEDICAL MANAGEMENT FOR MAJOR OM (CTO). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RAMISTAR 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. PROLOMET-XL 25 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122
7900

**Na
me**

Mr. GUNDA
LAXMINARAYA
NA

**Patient
Identifier**

ARHIP54788

Age

46Yr
2Mth
3Days

Sex

Male

**Date of
Admission**

19-
Feb-
2022

**Date of
Discharge
MLC No**

Address

5-42, LAXMIPOOR
JAGTIAL ,Karimna
gar,Telangana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U8

**Primary
Consultant**

Dr. Vidya Sagar
A--CARDIOLOGY

CORONARY ARTERY DISEASE, IWM

SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%

R/F T2DM

S/P CORONARY ANGIOGRAM DONE ON 21/02/2022 - CAD-TVD
PLAN CABG.

C/o chest pain since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 46 years old male patient Mr. GUNDA LAXMINARAYANA came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , IWMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, R/F T2DM, S/P CORONARY ANGIOGRAM DONE ON 21/02/2022 - CAD-TVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDACE 2.5MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
6. TAB. GLYCOMET-SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

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Name

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ARHIP54782

Age

63Y
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Sex

Male

**Date
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18-
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RAMAJIPET,Karimna
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Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, IWMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

R/F T2DM, HTN

S/P CORONARY ANGIOGRAM DONE ON 21/02/2022 - CAD-TVD

PLAN CABG.

C/o chest pain since 2 days a/w sweatings, SOB

At Admission

Afebrile

PR: 80/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 63 years old male patient Mr. ANUGANTI NARSAIAH came with c/o chest pain since 2 days a/w sweatings, SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, R/F T2DM, HTN, S/P CORONARY ANGIOGRAM DONE ON 21/02/2022 – CAD-TVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RAMISTAR 2.5MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

NANDAM CABG

NARENDER Cranioplasty

KOMURIAH TURP

54818 MAHESH 26

AZOSPERMIA

S/P: TESTICULAR BIOPSY DONE ON 22-02-22

Patient came for testicular biopsy

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 26yr old male Mr. MAHESH came for testicular biopsy. All necessary investigations done and diagnosed as AZOSPERMIA, TESTICULAR BIOPSY DONE ON 22-02-22. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: AUGMENTIN DUO 500MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: PAN 40 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: A TO Z ONCE DAILY AT 2PM FOR 5 DAYS.
4. TAB: DOLO 650 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
5. SYP. KCET 10 ml THRICE DAILY AT 8AM 2PM 8PM

Review after 7 days in UROLOGY OPD.

ARH1.000
1227068

**N
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Mrs.
KOMUR
AMMA
PONNA
M

**Patient
Identifier**

ARHIP54705

Age

57
Yr
0M
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28
Da
ys
10
-

Sex

Female

**Date
of
Admission**

Fe
b-
20
22

**Date of
Discharge
MLC No**

Address

H.NO:8-
12/1,REGAIMADDIKUNTA,SULTHANABAD,PEDDAP
ALLY,Other,Telangana

**Ward/
Bed
No**

Fir
st
Flo
or,
CT
PO
ST
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Be
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no
:C
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2

**Primary
Consultant**

Dr SOMASHEKAR K

CAD+LMCA +TVD + HTN+ S/P NSTEMI

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG to RI
& RCA] DONE ON 18/02/2022.

C/o chest pain a/w SOB since 3 days

K/c/o HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 57 years old female patient Mrs. KOMURAMMA PONNAM presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CAD+LMCA +TVD + HTN+ S/P NSTEMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG to RI & RCA] DONE ON 18/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED: PARADOXICAL SEPTAL MOTION, FAIR LV FUNCTION, EF-55%, NO PE/CLOT/VEG

BMI is 26.9 kg/m².

Sr. Creatinine report on 19.02.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. CARDARONE 100 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 10) USE OWN HYPERTENSIVE MEDICATION AS BEFORE

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.00012 27960	Name	Mr. KOMUR AIAH T ...	
Patient Identifier	ARHIP54823	Age	55Y r 0Mt h 2Da ys
Sex	Male	Date of Admission	21- Feb- 202 2
Date of Discharge MLC No			
Address	KANDIKATKUR, RAJANNS SIRICILLA,Karimnagar, Telangana	Ward/ Bed No	First Floor, HD U, Bed no: HD U 2
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT

NORMAL LV FUNCTION [EF-60%]

R/F : HTN, TOBACCO CHEWING

CORONARY ANGIOGRAM (23/02/2022) -CAD-Slow flow in coronaries

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. KOMURIAH came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, NORMAL LV FUNCTION [EF-60%], R/F : HTN, TOBACCO CHEWING, CORONARY ANGIOGRAM (23/02/2022) -CAD-Slow flow in coronaries, plan medical management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.

4. TAB: TAZLOC H 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB: DILZEM SR 90MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001227997		Name	Mr. MUZAFFAR HUSSAIN
Patient Identifier	ARHIP54812	Age	63Yr 0Mth 2Days
Sex	Male	Date of Admission	21-Feb-2022
Date of Discharge			
MLC No			
Address	ASIFABAD ,Telangana	Ward/ Bed No	First Floor, HDU, Bed no:HD U 4
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

COMPLETE HEART BLOCK (DRUG INDUCED)

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN, T2DM, SMOKING

CORONARY ANGIOGRAM DONE ON 21/02/2022 - CAD-SVD (LCX)

TPI DONE ON 21/02/2022, REMOVED ON 22/02/2022

PLAN: PTCA+DES TO OM

C/o giddiness and vomiting, right arm numbness since 2 days

K/C/O T2DM,HTN

AT ADMISSION:

Afebrile

PR: 55/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 96%

P/A: Soft

A 63 years old male patient Mr. MUZAFFAR HUSSAIN came with c/o giddiness and vomiting, right arm numbness since 2 days. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK (DRUG INDUCED), NORMAL LV SYSTOLIC FUNCTION, EF-60%, R/F: HTN, T2DM, SMOKING, CORONARY ANGIOGRAM DONE ON 21/02/2022 - CAD-SVD (LCX), TPI DONE ON 21/02/2022, REMOVED ON 22/02/2022, PLAN: PTCA+DES TO OM. Patient attendants are willing to go RTC health center for further treatment, hence patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 80MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. GLYCOMET SR 500 MG ONCE DAILY AFTER LUNCH TO CONTINUE.
- 5) TAB. TAZLOC 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. VELOZ 20MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001227
842

**Na
me**

Mrs. D
LAXMI

**Patient
Identifier**

ARHIP54771

Age

60Yr
0Mth
6Days

Sex

Female

**Date of
Admission**

17-
Feb-
2022

**Date of
Discharge
MLC No**

Address

3-7-
201,VAVILALAPALLY,Karimnagar,Tel
angana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 10

**Primary
Consultant**

Dr Chandra Shekar Sathineni(MD
(Internal Medicine))--INTERNAL
MEDICINE

ACUTE GASTROENTERITIS DKA

C/o loose stools 2 episodes
Shortness of breath
vomiting multiple episodes since 1 day

AT ADMISSION:

Afebrile

PR: 100/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 60 years old female patient Mrs. D LAXMI came with c/o loose stools 2 episodes, shortness of breath, vomiting multiple episodes since 1 day. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, DKA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
 - 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
 - 3) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
 - 4) TAB. ARVAST CV ONCE DAILY AT 8PM FOR 10 DAY
 - 5) INJ. TOUJEO 30 Units ONCE DAILY AT 8PM FOR 10 DAY
 - 6) INJ. APHIDRA 20 Units TWICE DAILY AT 8AM AND 8PM FOR 10 DAY

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.000122 7923		Na me	Mr. K SUMAN	
Patient Identifier	ARHIP54801	Age	33Yr 0Mth 1Days	
Sex	Male	Date of Admission	20- Feb- 2022	
Expired Date	21-Feb-2022			
MLC No				
Address	MANCHERIAL,TEKUMATLA,Tel ngana	Ward/Bed No	First Floor, MICU, Bed no:MI CU 12	
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE	Consultants		
Surgeons		Anesthesiolo gists		

☐
Diagnosi
S

Disease	Disease Type
ACUTE RESPIRATORY DISTRESS SYNDROME ,MULTIPLE ORGAN DYSFUNCTIONOM SYNDROME	

C/o fever with chills since 5 days a/w SOB,

AT ADMISSION:

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 33 years old male patient Mr. SUMAN came with c/o fever with chills since 5 days a/w SOB. All necessary investigations were done and diagnosed as ACUTE RESPIRATORY DISTRESS SYNDROME ,MULTIPLE ORGAN DYSFUNCTION SYNDROME. Managed conservatively. Patient condition and prognosis was explained to patient attendants. On 20.02.2022 patient developed bradycardia and became unresponsive, immediately CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 01.13 AM on 21/02/2022

CAUSE OF DEATH

CARDIORESPIRATORY ARREST SECONDARY TO ACUTE RESPIRATORY DISTRESS SYNDROME ,MULTIPLE ORGAN DYSFUNCTION SYNDROME

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ARHIP54746

Female

19-Feb-2022

H.NO:4-
19,KACHAPUR,JULAPALLY,
PEDDAPALLY,Other,Telang
ana

Dr. Venkat Reddy
Almareddi
(MS(Orthopaedics),MBA(H
ealthcare),Fellow in Joint
Replacement,Fellow in
Shoulder
Surgery(USA),Fellow in
Arthroscopy(SIOR),Consult
ant Orthopaedic
Surgeon)--ORTHOPAEDICS

Dr. Venkat Reddy
Almareddi
(MS(Orthopaedics),MBA(H
ealthcare),Fellow in Joint
Replacement,Fellow in
Shoulder
Surgery(USA),Fellow in
Arthroscopy(SIOR),Consult
ant Orthopaedic
Surgeon)--ORTHOPAEDICS

Age

75Yr
0Mth
4Days

**Date
of
Admi
ssion**

15-
Feb-
2022

**Ward
/Bed
No**

First
Floor,
SICU,
Bed
no:SIC
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**Cons
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Dr
Subba
Reddy
Kuppa
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ANAES
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Diagnosis

Diagnosis

Disease	Disease Type
POST MYOCARDIAL INFARCTION.	

Patient alleged h/o slip and fall at home on 05/02/2022

C/o pain and swelling in left leg

AT ADMISSION:

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old female patient Mrs. LACHAVVA ELETI came with patient alleged h/o slip and fall at home on 05/02/2022, c/o pain and swelling in left leg. All necessary investigations were done and diagnosed as IT FRACTURE LEFT FEMUR, S/P: LEFT DHS done on 17/02/2022, POST MYOCARDIAL INFARCTION. Patient condition and prognosis was explained to patient attendants, patient was on inotropic support. On 19.02.2022 at 7.30 AM patient had sudden cardiac arrest became unresponsive, immediately CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. Patient not reverted to Normal Sinus Rhythm. Pupils

dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 07.54 AM on 19/02/2022

CAUSE OF DEATH

POST MYOCARDIAL INFARCTION

Nandaiah cabg

Narender cranioplasty

Hanish hernia repair gotham

Shankar pcnl

ARH1.00012179 38		Name	Mr. MOHMD KHASIM	
Patient Identifier	ARHIP54826		Age	60Yr 6Mth 29Days
Sex	Male		Date of Admission	21-Feb-2022
Date of Discharge				
MLC No				
Address	DANDEPALLE,Telangana		Ward/ Bed No	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE , ACUTE AWWMI

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

R/F: SMOKING

S/P CORONARY ANGIOGRAM DONE ON 22/02/2022 – CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

C/o left sided chest pain, a/w sweating since 2 days

At Admission

Afebrile

PR: 86/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 60 years old male patient Mr. MOHMD KHASIM came with c/o left sided chest pain, a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AAMI, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: SMOKING, S/P CORONARY ANGIOGRAM DONE ON 22/02/2022 - CAD-TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.00012
28074

Name

Mr.
AMIT
KUMAR

**Patient
Identifier**

ARHIP54842

Age

26Yr
0Mth
1Days

Sex

Male

**Date
of
Admission**

23-Feb-
2022

**Date
of
Discharge
MLC
No**

Address

RAMAGUNDAM,Karimnagar
,Telangana

**Ward/
Bed
No**

First
Floor,
MICU,
Bed no:M
ICU
12

**Primary
Consultant**

DR. SRI KARAN UDDESH --
INTERNAL

54842 AMIT KUMAR

HYMENOPTERA ENVENOMATION

Alleged history of bee stings to face head and torso on 23/02/22 at 8:30 a.m.
complaints of uneasiness and shortness of breath since then.
History of vomitings and loose stools 2 episodes.

AT ADMISSION:

Pt conscious, coherent
Afebrile
PR: 93/min
BP: 160/100mmHg
RS: BAE+, Clear
CVS: S1S2
RR: 17/min
SPO2: 100% on room air
P/A: Soft, BS+
O/E Multiple bee stings on face, head and torso

Facial puffiness +
Periorbital swelling +

A 26-year-old male patient Mr. AMIT KUMAR presented with the above-mentioned complaints. Patient was admitted and evaluated thoroughly and was diagnosed as HYMENOPTERA ENVENOMATION. Multiple Bee stings has been removed from patient head, forearm and torso. Patient was managed with patient was managed with antiemetics , antacids and analgesics, anti- diarrheic and was discharged in haemodynamically stable condition with discharge medications

DISCHARGE MEDICATION:

1.TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 2 DAYS.

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE.

ARH1.00012280
00

Name

Mr. BATTI
GIRIDHAR
SING

**Patient
Identifier**

ARHIP54815

Age

53Yr
10Mth
3Days

Sex

Male

**Date of
Admission**

21-Feb-
2022

**Date of
Discharge
MLC No**

Address

12-118, MANTHANI
PEDDAPALLI, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 8

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, INFERIOR WALL MI, NO TLT, SR

MILD LV DYSFUNCTION [EF-47%]

R/F : HTN, SMOKER, ALCOHOLIC

CORONARY ANGIOGRAM (24/02/2022) -Recanalized LAD (Myocardial
bridging)

PLAN MEDICAL MANAGEMENT

C/o left sided chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 120/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old male patient Mr. BATTI GIRIDHAR SING came with c/o left sided chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, INFERIOR+ANTERIOR WALL MI, NO TLT, MILD LV DYSFUNCTION [EF-47%], R/F : HTN, SMOKER, ALCOHOLIC, CORONARY ANGIOGRAM (24/02/2022) -Recanalized LAD (Myocardial bridging), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TELMA H 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. MET-XL 25MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000122
7870

Name

Mrs.
MATCHA
SAROJAM
MA

**Patient
Identifier**

ARHIP54784

Age

75Y
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18-
Feb
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Sex

Female

**Date of
Admission**

**Date
of
Discharge
MLC
No**

19-Feb-2022

Address

SIRPUR
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mal,Telanga
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**Ward/Bed
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**Primary
Consultant**

Dr. Vidya
Sagar A--
CARDIOLOG
Y

Consultants

Surgeons

Dr. Vidya
Sagar A--
CARDIOLOG
Y

Anesthesiologists

Diagnosis



Diagnosis

Disease	Disease Type
CAD-NSTEMI WITH ACCELERATED HYPERTENSION. SR,MODERATE LV DYSFUNCTION. CAD-OLD AWM.I.S/P-PTCA+DES TO LAD IN 2021. R/F-HYPERTENSION,TYPE 2 DIABETES MELLITUS. S/P-CAG (19/02/2022)-SVD(PROXIMAL LAD SIGNIFICANT ISR). ADVICE-EARLY CABG.	

CAD-NSTEMI WITH ACCELERATED HYPERTENSION.
SR,MODERATE LV DYSFUNCTION.
CAD-OLD AWMi.S/P-PTCA+DES TO LAD IN 2021.
R/F-HYPERTENSION,TYPE 2 DIABETES MELLITUS.
S/P-CAG (19/02/2022)-SVD(PROXIMAL LAD SIGNIFICANT ISR).
ADVICE-EARLY CABG.

C/o left sided chest pain (non radiating) since 5 days a/w heaviness chest and breathlessness

At Admission

Afebrile

PR: 78/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 72 years old male patient Mr. DEVAIAH came with c/o retrosternal chest pain, radiating to the back a/w sweating since 2-3 days. K/c/o chronic smoker & COPD. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWMi, SEVERE LV DYSFUNCTION, COPD, R/F HTN, SMOKING ALCOHOL, S/P CORONARY ANGIOGRAM DONE ON 30/04/2022 – CAD-DVD, PLAN CABG. Patient is planned for CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DILZEM 30 MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
8. TAB. DERIPHYLLIN RETARD 150 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

QUIT SMOKING

REVIEW AFTER 7 DAYS IN CARDIAC OPD

54845 GANGARAM 66

CORONARY ARTERY DISEASE, LWMI

SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%]

R/F : HTN

PLAN: CAG

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 66 years old male patient P.GANGARAM came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and

diagnosed as CORONARY ARTERY DISEASE, LWMI, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50%], R/F : HTN, PLAN: CAG. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012278
95

Name

Mr. CHIPPA
BHASKAR

**Patient
Identifier**

ARHIP54791

Age

53Yr
2Mth
6Days

Sex

Male

**Date of
Admission**

19-Feb-
2022

**Date of
Discharge
MLC No**

Address

12-33/2 RUDRANGI
RAJANNA, Karimnagar, Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
2

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI

SR, MILD LV DYSFUNCTION, EF-50%

R/F: HTN, DENOVO T2DM

CORONARY ANGIOGRAM DONE ON 22/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 22/02/2022

C/o chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 53 years old male patient Mr. CHIPPA BHASKAR came with c/o chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, MILD LV DYSFUNCTION, EF-50%, R/F: HTN, DENOVO T2DM, CORONARY ANGIOGRAM DONE ON 22/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 24 MM METAFOR DONE ON 22/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

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**N
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Mrs. ERRA
LAXMI

**Patient
Identifier**

ARHIP54635

Age

66Yr 1Mth
22Days

Sex

Female

**Date of
Admission**

06-Feb-2022

**Expired
Date
MLC No**

23-Feb-2022

Address

1-122/3,
KHAIRAGAON
KOMARAM BHEEM
9182827179 ,Tela
ngana

**Ward/Bed
No**

CT POST, CT
POST, Bed
no:CT 3

**Primary
Consultant**

Dr SOMASHEKAR
K(MS,MCH(CTVS),C
onsultant-Cardio
Thoracic &
Vascular
Surgeon)--C T
SURGERY

Consultants

Surgeons

Dr SOMASHEKAR
K(MS,MCH(CTVS),C
onsultant-Cardio
Thoracic &
Vascular
Surgeon)--C T
SURGERY

Anesthesiologists

Dr.
K.S.D.KRISH
NA KIRAN--
ANAESTHESIOLOGY

Diagnoses

Diagnosis

Diseases

Disease

e	Type

CORONARY ARTERY DISEASE,ANTERIOR WALL MYOCARDIAL INFRACTION,MODERATE LV DYSFUNCTION,LOW CARDIAC OUTPUT VENTRICULAR FIBRILLATION.S/P CORONARY ARTERY BYPASS GRAFTING DONE ON 21/02/2022.

C/o chest pain a/w SOB since 10 days

AT ADMISSION:

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 66 years old female patient Mrs. ERRA LAXMI came with c/o chest pain a/w SOB since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE,ANTERIOR WALL MYOCARDIAL INFRACTION,MODERATE LV DYSFUNCTION,LOW CARDIAC OUTPUT VENTRICULAR FIBRILLATION.S/P CORONARY ARTERY BYPASS GRAFTING DONE ON 21/02/2022. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 08.53 PM on 23/02/2022.

CAUSE OF DEATH:

CARDIOPULMONARY ARREST SECONDARY TO CORONARY ARTERY
DISEASE,ANTERIOR WALL MYOCARDIAL INFRACTION,MODERATE LV DYSFUNCTION,LOW
CARDIAC OUTPUT VENTRICULAR FIBRILLATION.S/P CORONARY ARTERY BYPASS GRAFTING
DONE ON 21/02/2022.

PatientDetails

UHID	ARH1.0001228108	Name	Mrs. SANDYA G
Patient Identifier	ARHIP54855	Age	28Yr 0Mth 2Days
Sex	Female	Date of Admission	24-Feb-2022
Date of Discharge			
MLC No			
Address	KMR,Karimnagar,Telangana	Ward/Bed No	First Floor, SICU, Bed no:SICU 1
Primary Consultant	DR. SUBRAT KUMAR SOREN		

TRAUMATIC BRAIN INJURY
RIGHT TEMPORAL EDH, LEFT FRONTAL LOBE CONTUSION
DIFFUSE CEREBRAL OEDEMA

Patient alleged history of RTA 2 Wheeler jumped from bike seeing another by coming close to her on 23-02-2022 at around 5:30 p.m., following which she sustained injury over head associated with 4-5 episodes of vomitings and loss of consciousness for 5 minutes

AT ADMISSION:

Patient drowsy

Afebrile

PR: 57/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% on room air

P/A: Soft, BS+

A 28 years old female patient came with alleged history of RTA 2 Wheeler jumped from bike seeing another by coming close to her on 23-02-2022 at around 5:30 p.m.,

following which she sustained injury over head associated with 4-5 episodes of vomitings and loss of consciousness for 5 minutes. All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY, RIGHT TEMPORAL EDH, LEFT FRONTAL LOBE CONTUSION, DIFFUSE CEREBRAL OEDEMA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. PANTOCID 40MG ONCE DAILY AT 7PM (BBF) FOR 10 DAYS.
- 3) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. CALPOL SOS
- 5) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001
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Name

Mr.
SANJE
EV
KOKK
ERA

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ARHIP54798

Age

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Feb-
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Sex

Male

Date
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H.NO:5-1-
135,KORUTLA,JAGITAIL,Othe
r,Telangana

Ward
/Bed
No

Prima
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Cons
ultant

Dr. Vidya Sagar A--
CARDIOLOGY

ARH1.000
1227922

Name

Mr.
E
RAJ
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Pati
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Iden
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ARHIP54805

Age

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Sex

Male

Date of
Admissio
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Date
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20-Feb-2022

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MLC
No**

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HANMAJIPET,JAGITYAL,Karimn
agar,Telangana

**Ward/
Bed No**

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**Prim
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Dr. Vidya Sagar A--
CARDIOLOGY

Dr. Vidya Sagar A--
CARDIOLOGY

**Consulta
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**Anesthes
iologists**

Diagnosi
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Diagnosis

Diseas e	Disease Type
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CAD UNSTABLE ANGINA,
ATYPICAL CHEST PAIN,SR,NORMAL LV SYSTOLIC FUNCTION,(EF-60%),
CAG DONE ON(20/02/2022)
NORMAL CORONARIES,
RCA ANOMALOUS ORIGIN ARISING FROM LEFT SINUS,
PLAN;MEDICAL MANAGEMENT.
R/F;ALCOHOL.--CICU

C/o chest pain a/w SOB and sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 45 years old male patient RAJESH came with c/o chest pain a/w SOB and sweating since 1 day. All necessary investigations were done and diagnosed as CAD UNSTABLE ANGINA, ATYPICAL CHEST PAIN,SR,NORMAL LV SYSTOLIC FUNCTION,(EF-60%), CAG DONE ON(20/02/2022) NORMAL CORONARIES, RCA ANOMALOUS ORIGIN ARISING FROM LEFT SINUS,PLAN;MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. AZTOLET 10MG ONCE DAILY AT 2PM FOR 10 DAYS.
2. TAB. DILZEM SR 90MG ONCE DAILY AT 2PM FOR 10 DAYS.
3. TAB. VELOZ 20MG ONCE DAILY AT 8AM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001
227848

Name

Mr.
SANJ
EEV
KOKK
ERA

**Patient
Identifier**

ARHIP54798

Age

39Yr
0Mth
8Days

Sex

Male

**Date
of
Admission**

20-
Feb-
2022

**Date
of
Discharge
MLC
No**

Address

H.NO:5-1-
135,KORUTLA,JAGITAIL,Other,
Telangana

**Ward
/Bed
No**

First
Floor,
CICU
, Bed
no:CI
CU10

**Primary
Consultant**

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE- NON-ST ELEVATION
MYOCARDIAL INFARCTION, SINUS RHYTHM,
MILD LV SYSTOLIC DYSFUNCTION (EF-45%)
CORONARY ANGIOGRAM DONE ON 22-02-2022-CAD-DVD (LCX, RCA)
PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY TO LCX WITH 3V ASTRA
3.0 X 24 MM, OM1 WITH 3.0 X 24 MM DONE ON 24-02-2022
RISK FACTOR: TYPE II DIABETIC MELLITUS DENOVO, HYPERTENSION

C/o gradual onset of left sided chest pain since 4 days radiating to left arm
associated with sweating

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 39 years old male patient Mr. SANJEEV KOKKERA came with c/o gradual onset of left sided chest pain since 4 days radiating to left arm associated with sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- NON-ST ELEVATION, MYOCARDIAL INFARCTION, SINUS RHYTHM, NO THROMBOLISATION, MILD LV SYSTOLIC DYSFUNCTION (EF-45%), CORONARY ANGIOGRAM DONE ON 22-02-2022-CAD-DVD (LCX, RCA), PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY TO LCX WITH 3V ASTRA 3.0 X 24 MM, OM1 WITH 3.0 X 24 MM DONE ON 24-02-2022, RISK FACTOR: TYPE II DIABETIC MELLITUS DENOVA, HYPERTENSION. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) TAB. SARTEL 20 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. VOGS 0.3 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000 1227913		N a m e	Mr. KAMALAK AR THANGAL LAPALLI	
Patient Identifier	ARHIP54797		Age	24Y r 0Mt h 7Da ys 19- Feb - 202 2
Sex	Male		Date of Admission	
Date of Discharge MLC No				
Address	H.NO:3- 96,STHAMBHAMPALLI,BOINPALLI,RAJANNASIRI CILLA,Other,Telangana		Ward/ Bed No	Firs t Floo r, CIC U , Bed no: CIC U9
Primary Consultant	Dr. Vidya Sagar A			

CORONARY ARTERY DISEASE- INFERIOR WALL MYOCARDIAL INFARCTION,
SINUS RHYTHM, NO THROMBOLISATION
MILD LV SYSTOLIC DYSFUNCTION (EF-55%)
CORONARY ANGIOGRAM DONE ON 19-02-2022-CAD-DVD (LAD, RAMUS)
PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY TO RAMUS WITH
METAFOR 3.0 X 19 MM DONE ON 19-02-2022, LAD WITH METAFOR 3.0 X 13 MM DONE
ON 24-02-2022
RISK FACTOR: HYPERTENSION, TYPE- II DIABETIC MELLITUS DENOVO

C/o chest pain with SOB associated with sweating since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 24 years old male patient Mr. KAMALAKAR THANGALLAPALLI came with c/o chest pain with SOB associated with sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- NON-ST ELEVATION, MYOCARDIAL INFARCTION, SINUS RHYTHM, NO THROMBOLISATION, MILD LV SYSTOLIC DYSFUNCTION (EF-45%), CORONARY ANGIOGRAM DONE ON 22-02-2022-CAD-DVD (LCX, RCA), PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY TO LCX WITH 3V ASTRA 3.0 X 24 MM, OM1 WITH 3.0 X 24 MM DONE ON 24-02-2022, RISK FACTOR: TYPE II DIABETIC MELLITUS DENOVA, HYPERTENSION. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 150 G TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS
LIFE STYLE MODIFICATIONS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54884

HYPONATRAEMIA
STATUS EPILEPTICUS
MULTIPLE TERRITORY INFARCTS
HYDROPNEUMOTHORAX
POST CARDIAC ARREST - ROSC

C/o 1 episode of seizures
H/o tongue bite, irritable

Known case of hypertension, epilepsy (not on medication since last few days)

AT ADMISSION:

PR: 118/min

BP: 200/110mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 60 years old female patient GOUSIYA BEGUM came with c/o 1 episode of seizures, h/o tongue bite, irritable. Known case of hypertension, epilepsy (not on medication since last few days). All necessary investigations were done and diagnosed as HYPONATRAEMIA, STATUS EPILEPTICUS, MULTIPLE TERRITORY INFARCTS, HYDROPNEUMOTHORAX, POST CARDIAC ARREST - ROSC. Managed conservatively. Poor prognosis explained to patient attendants. They want to leave against medical advice, so patient is being discharged under LAMA

ARH1.000 1228006		N a m e	Mrs. MADHARA BOINA HANMAKKA	
Patient Identifier	ARHIP54830		Age	65Yr 0Mth 5Days
Sex	Female		Date of Admission	22-Feb-2022
Date of Discharge				
MLC No				
Address	KAKARLAPALLI,MANTHANI,PEDDAPALLI,Karimnagar,Telangana		Ward/Bed No	First Floor, CICU , Bed no:CI CU13
Primary Consultant	Dr. Vidya Sagar A			

CORONARY ARTERY DISEASE- ANTERIOR WALL MYOCARDIAL INFARCTION,
SEVERE LV DYSFUNCTION (EF-25%)
CORONARY ANGIOGRAM DONE ON 25-02-2022-TVD (LAD,LCX,RCA)
PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 108/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

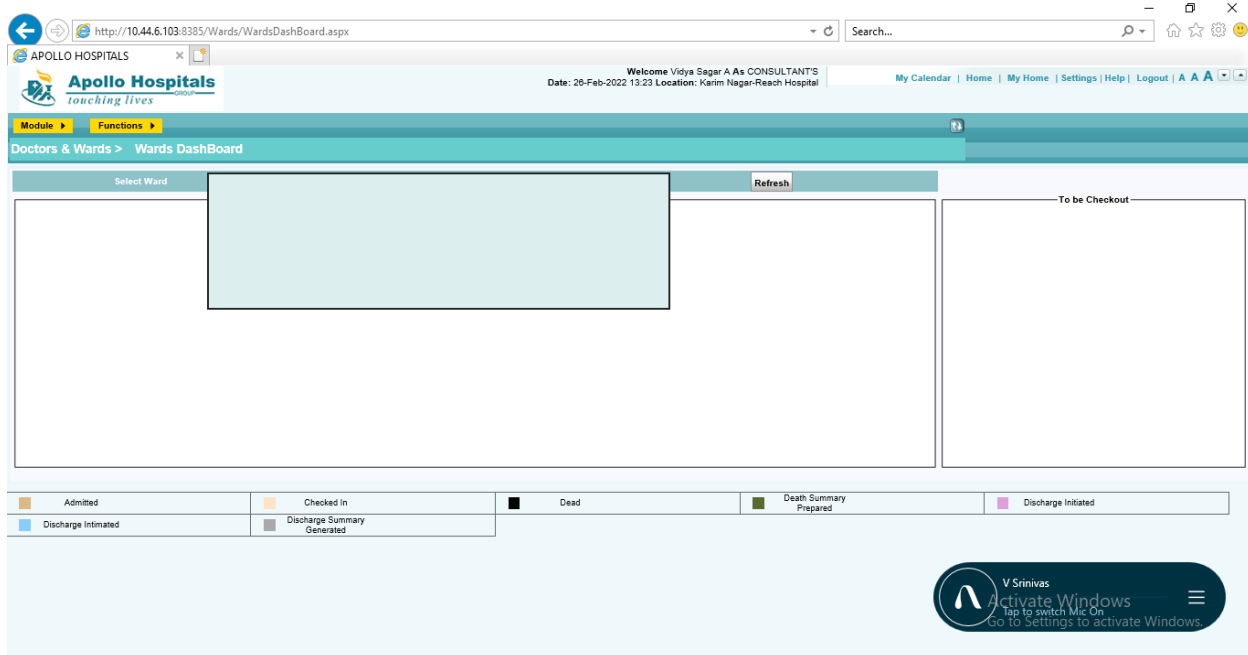
P/A: Soft

A 65 years old female patient Mrs. MADHARABOINA HANMAKKA came with c/o retrosternal chest pain since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- ANTERIOR WALL MYOCARDIAL INFARCTION, SEVERE LV DYSFUNCTION (EF-25%), CORONARY ANGIOGRAM DONE ON 25-02-2022-TVD (LAD,LCX,RCA), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD



ARH1.000 1227686	Name	Mrs. PULLAIA HGARI SUGUN A	
Patient Identifier	ARHIP54718	Age	69Yr 1Mth 6Days
Sex	Female	Date of Admission	12-Feb-2022
Expired Date MLC No	18-Feb-2022		
Address	8-14, GUNDARAM SIDDIPET ,Kari mnagar,Telang ana	Ward/ Bed No	First Floor, SICU, Bed no:SICU 6
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS) ,Consultant Urologist)-- UROLOGY	Consultants	
Surgeons	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS) ,Consultant Urologist)-- UROLOGY	Anesthesiologists	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY
Diagnosis	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 10px;"></div> <div> Diagnosis S </div> </div>		

Disease	Disease Type
.	Pd

POST TURBT

C/o burning micturition, difficulty in voiding urine since 7 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-99%

A 69 yrs old female patient came Mrs. PULLAIAHGARI SUGUNA came with c/o burning micturition, difficulty in voiding urine since 7 days. All necessary investigations done and diagnosed as Ca. BLADDER, SURGERY: TURBT DONE ON 16/02/2022. Patient was on ventilator. On 18/02/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 02.55 PM on 26/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO POST TURBT

54807 basappa 57

TRAUMATIC BRAIN INJURY
MULTIPLE HAEMORRHAGIC CONTUSIONS

Patient alleged history of RTA Paediatrician vs LORY at 8 p.m , following which he sustained injury over head

K/C/O PTCA 6 months back

AT ADMISSION:

Patient irritable

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96% on room air

P/A: Soft,

GCS-14/15

A 57 years old male patient P. BASAPPA came with alleged history RTA Paediatrician vs LORY at 8 p.m , following which he sustained injury over head. All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY, MULTIPLE HAEMORRHAGIC CONTUSIONS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. AXCER 90 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 3) TAB. MONOTRATE SR 30 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 4) TAB. ECOSPRIN 75 MG ONCE DAILY AT 8AM TO CONTINUE
- 5) TAB. ROZAVEL 20 MG ONCE DAILY AT 8AM TO CONTINUE
- 6) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN NEUROSURGERY OPD

ARH1.0001 228146		Name	Mrs. PUSHPALAT HA INTI
Patient Identifier	ARHIP54858	Age	48Yr 7Mth 2Days
Sex	Female	Date of Admission	24-Feb-2022
Date of Discharge			
MLC No			
Address	NTPC,JYOTHINAGAR, RAMAGUNDAM ,Telangana	Ward/Bed No	First Floor , MIC U, Bed no:M ICU 5

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultant
s**

Surgeons

**Anesthesio
logists**



Diagnosi
s

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
CEREBROVASCULAR ACCIDENT WITH DYSARTHRIA THROMBOCYTOPENIA MITRAL VALVE PROLAPSE WITH SEVERE MITRAL REGURGITATION,SR NORMAL LV FUNCTION HYPERTENSION.	

C/o Chest pain, palpitations, fever cough with generalised weakness since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

Treated with

Inj Ciractam
Inj Milifast
Inj Ascorjet
Inj Pantocid
Inj Glutabest
Tab Tonact
Tab Aldactone
Tab Dolo
Tab Ramistar
Tab Betalac
Tab Aldactone
Tab Clopitab
Tab Naradom
Tab Clopitab

A 48 years old female patient Mrs. PUSHPALATHA INTI came with c/o chest pain, palpitations, fever cough with generalised weakness since 3 days. All necessary investigations were done and diagnosed as CEREBROVASCULAR ACCIDENT WITH DYSARTHRIA, THROMBOCYTOPENIA, MITRAL VALVE PROLAPSE WITH SEVERE MITRAL REGURGITATION,SR, NORMAL LV FUNCTION, HYPERTENSION. Neurology consultation was taken advice followed. Patient attendants were explained about the patient condition as patient having recurrent dysarthria. Patient attendants has willing for higher centre. Patient is being discharged in haemodynamically stable condition.

ARH1.00012 28220		Na me	Mr. KURRA SAILU
Patient Identifier	ARHIP54883	Age	54Yr 0Mth 6Days
Sex	Male	Date of Admis sion	26- Feb- 2022
Date of Discharge MLC No			
Address	4-56/1, NAMPELLY,RAJANNA SIRCILLA,Sircilla,Tel angana	Ward/ Bed No	First Floor, CICU , Bed no:CIC U10
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT

SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F: HTN, TOBACCO, ALCOHOL

CORONARY ANGIOGRAM DONE ON 28/02/2022 - CAD-TVD (LAD,LCX,RCA)

PTCA+DES TO RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 28/02/2022

C/o left sided chest pain a/w SOB, giddiness since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old male patient Mr. KURRA SAILU came with c/o left sided chest pain a/w SOB, giddiness since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV FUNCTION, SR, NO TLT, EF-60%, R/F: HTN, TOBACCO, ALCOHOL , CORONARY ANGIOGRAM DONE ON 28/02/2022 – CAD-TVD (LAD,LCX,RCA), PTCA+DES TO RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 28/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELMA 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) SYP ASCORYL D 2tsp ONCE DAILY AT 8PM

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000
1228176

Name

Mr.
GATLA
RAJES
HWAR

**Pati
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Iden
tifier**

ARHIP54871

Age

68Y
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Sex

Male

**Date
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**Prim
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Dr. Vidya
Sagar A

CORONARY ARTERY DISEASE, AWTMI, NO TLT

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

R/F: HTN, T2DM, ALCOHOL

CORONARY ANGIOGRAM DONE ON 27/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 40 MM 3V ASTRA DONE ON 27/02/2022
ON MECHANICAL VENTILATOR SUPPORT (27/02/2022)
CKD

C/o chest pain a/w SOB since 2-3 days

AT ADMISSION:

Afebrile

PR: 86/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 68 years old male patient Mr. GATLA RAJESHWAR came with c/o chest pain a/w SOB since 2-3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWM, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, R/F: HTN, T2DM, ALCOHOL, CORONARY ANGIOGRAM DONE ON 27/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 40 MM 3V ASTRA DONE ON 27/02/2022, ON MECHANICAL VENTILATOR SUPPORT (27/02/2022), CKD. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RECLIDE MR ONCE DAILY AT 8AM BEFORE BREAK FAST TO CONTINUE.
- 7) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 2PM AFTER LUNCH TO CONTINUE.
- 8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001 228360		N a m e	Mrs. SHAME EMA KHATO ON	
Patient Identifier	ARHIP54931		Age	75Yr 0Mth 1Days
Sex	Female		Date of Admis sion	02- Mar- 2022
Date of Discharge MLC No				
Address	KARIMNAGAR,Karimnaga r,Telangana		Ward/ Bed No	Groun d Floor, Emer gency Ward, Bed no:EM E7
Primary Consultan t	Dr Chandra Shekar Sathineni(MD			

LOWER RESPIRATORY TRACT INFECTION

C/o shortness of breath grade 3 to 4 since 1 day
Known case of hypertension on irregular medication

AT ADMISSION:

Afebrile

PR: 89/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 75 years old female patient Mrs. SHAMEEMA KHATOON came with c/o shortness of breath grade 3 to 4 since 1 day. Known case of hypertension on irregular medication. All necessary investigations were done and diagnosed as LOWER RESPIRATORY TRACT INFECTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
- 2) TAB. ROSUVAS 40 MG ONCE DAILY AT 8PM TO CONTINUE
- 3) TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 4) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.000
1228316

Name

Mrs.
DASAR
I
RATHN
AMMA

**Pati
ent
Iden
tifier**

ARHIP54912

Age

81Yr
1Mth
3Da
ys

Sex

Female

**Date
of
Adm
issio
n**

28-
Feb-
2022

**Date
of
Disc
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e
MLC
No**

**Addr
ess**

5-8-12,
SHIVALAYAM
STREET ,Kari
mnagar,Tela
ngana

**War
d/
Bed
No**

First
Floor
,
CICU
,
Bed
no:C
ICU1
1

**Prim
ary
Cons
ulta
nt**

Dr. Vidya
Sagar A--
CARDIOLOG
Y

CORONARY ARTERY DISEASE, AWTMI

SR, SEVERE LV DYSFUNCTION, EF-25%

R/F : HTN

PLAN CORONARY ANGIOGRAM

C/o chest pain a/w SOB grade-2 since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 81 years old female patient Mrs. DASARI RATHNAMMA came with c/o chest pain a/w SOB grade-2 since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, R/F : HTN, PLAN CORONARY ANGIOGRAM . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001228
295

**Na
me**

Mr.
MASNA
NARSAIAH

**Patient
Identifier**

ARHIP54907

Age

83Yr
1Mth
3Days

Sex

Male

**Date of
Admission**

28-Feb-
2022

**Date of
Discharge
MLC No**

Address

10-127,
MUTYAMPETA
MANCHERIAL, Telang
ana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CIC
U1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, AWMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 28/02/2022 - CAD-SVD (LAD)

PTCA+DES TO PROXIMAL LAD WITH 3.0 X 32 MM METAFOR, MID LAD WITH 2.5 X 16
MM METAFOR
DONE ON 28/02/2022

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 83years old male patient Mr. MASNA NARSAIAH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 28/02/2022 - CAD-SVD (LAD), PTCA+DES TO PROXIMAL LAD WITH 3.0 X 32 MM METAFOR, MID LAD WITH 2.5 X 16 MM METAFOR DONE ON 28/02/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 3) TAB. CILODOC 40MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 4) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00011
08286

**Na
me**

Mr.
ANUGA
NTI
NARSAI
AH

**Patient
Identifier**

ARHIP54840

Age

63Y
r
8Mt
h
6D
ays

Sex

Male

**Date
of
Admis
sion**

23-
Feb
-
202
2

**Date of
Discharge
MLC No**

Address

RAMAJIPET,Karimnagar,T
elangana

**Ward/
Bed
No**

Firs
t
Flo
or,
CT
PO
ST,
Bed
no:
CT
5

**Primary
Consultant**

Dr SOMASHEKAR K

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA-LAD, SVG-PDA]
DONE ON 26/02/2022

CORONARY ARTERY DISEASE+ **LEFT MAIN CORONARY ARTERY
DISEASE**+ TRIPLE VESSEL DISEASE+ DIABETES MELLITUS+
HYPERTENSION+ LV DYSFUNCTION, S/P IWMI

C/o chest pain since 2 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 63 years old male patient Mr. ANUGANTI NARSAIAH presented to hospital with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+ **LEFT MAIN CORONARY ARTERY DISEASE** + TRIPLE VESSEL DISEASE+ DIABETES MELLITUS+ HYPERTENSION+ LV DYSFUNCTION, S/P IWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA-LAD, SVG-PDA] DONE ON 26/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION

MILD TR, PAH, EF-35%

BMI is 23.4 kg/m2.

Sr. Creatinine report on 27.02.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.

2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. THYRONORM 25MCG ONCE DAILY AT 7AM TO CONTINUE.
- 5) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

54934 RAJA KUMARI 47

DRUG INDUCED CARDIOMYOPATHY (CYTOTOXIC DRUGS)

ACUTE DECOMPENSATED HEART FAILURE

SEVERE LV SYSTOLIC DYSFUNCTION EF, 30%

SEVERE MR

R/F: HYPOTHYROIDISM , DENOVO T2DM

C/o profuse sweating and giddiness since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 47 years old female patient RAJA KUMARI came with c/o profuse sweating and giddiness since 1 day. Patient BP was not recordable. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATORY HEART FAILURE, SEVERE LV SYSTOLIC DYSFUNCTION EF, 30%, SEVERE MR, R/F : HYPOTHYROIDISM , DENOVO T2DM. Managed conservatively. Patient attendants want to go to Higher Centre for further management.

TREATMENT GIVEN:

1. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 20MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. THYRONORM 50MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
5. INJ. NORADRENALIN
6. INJ. ZOSTUM 1.5 gm IV TWICE DAILY AT 8AM 8PM TO CONTINUE.

MALLAVVA DHS VR

PULLA REDDY IM NAILING VR

JALANDHAR HERNIA

ARH1.00012
28330

Name

Mr.
SRIDH
AR
NOMU
LA

**Patient
Identifier**

ARHIP54919

Age

25Yr
0Mth
3Days

Sex

Male

**Date
of
Admission**

01-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

39-234
YAPAL,Karimnagar,Te
langana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CI
CU2

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, AWM
SR, MODERATE LV DYSFUNCTION, EF-35%
R/F: T2DM, HYPERCHOLESTOLEMIA, ALCOHOL, HYPERTENSION,
TLT WITH TENECTEPLASE DONE ON 01/03/2022

CORONARY ANGIOGRAM DONE ON 01/03/2022 - CAD-SVD (LAD)
RESCUE PTCA+DES TO LAD WITH XIENCE XPEDITION 3.5 X 12 MM METAFOR DONE ON
01/03/2022

C/o left sided chest pain, radiating to back a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 25 years old male patient Mr. SRIDHAR NOMULA came with c/o left sided chest pain, radiating to back a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, SR, MODERATE LV DYSFUNCTION, EF-35%, R/F: T2DM, HYPERCHOLESTROLEMIA, ALCOHOL, HYPERTENSION, TLT WITH TENECTEPLASE DONE ON 01/03/2022, CORONARY ANGIOGRAM DONE ON 01/03/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH XIENCE XPEDITION 3.5 X 12 MM METAFOR DONE ON 01/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BRILINTA 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. BETALOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. NEXPRO 20MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. GLYCOMET-SR 500MG ONCE DAILY AFTER LUNCH TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54917 rajyalaxmi 67

ADHF, [ACUTE PULMONARY EDEMA]

DCMP, LBBB, MILD MR, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

RF: T2DM, HTN

C/o sudden onset chest pain a/w sweating since 4 hrs

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 67years old female patient Mrs. RAJYALAXMI came with c/o sudden onset chest pain a/w sweating since 4 hrs . All necessary investigations were done and diagnosed as ADHF, [ACUTE PULMONARY EDEMA], DCMP, LBBB, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, RF: T2DM, HTN. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CARDACE 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARIVAS 3.125 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012282
60

Name

Mr. G
SHANKARAIA
H

Patient Identifier

ARHIP54894

Age

65Yr
0Mth
6Days

Sex

Male

Date of Admission

27-Feb-
2022

Date of Discharge
MLC No

Address

KARIMNAGAR
,
Choppadandi,
Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MIC
U 12

Primary Consultant

Dr. Vidya
Sagar A--
CARDIOLOGY

ADHF
RECURRENT HEART FAILURE
DCMP, SEVERE MR, MILD PAH, SR,
SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
R/F: ALCOHOL, TOBACCO

CORONARY ANGIOGRAM DONE ON 03-03-2022-CAD-Ostial diagonal significant
stenosis
PLAN MEDICAL MANAGEMENT

C/o chest pain a/w SOB since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. G SHANKARAIAH came with c/o chest pain a/w SOB since 1 month. All necessary investigations were done and diagnosed as ADHF, RECURRENT HEART FAILURE, DCMP, SEVERE MR, MILD PAH, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: ALCOHOL, TOBACCO, CORONARY ANGIOGRAM DONE ON 03-03-2022-CAD-Ostial diagonal significant stenosis, plan medical management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BENAGLIS 100MG ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. NUCARNIT 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. CONCAOR COR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RAMISTAR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 8) TAB. FRUSELAC DS ONCE DAILY AT 2PM TO CONTINUE.
- 9) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

54926 RAJAMANI 48

ATYPICAL CHEST PAIN WITH ECG CHANGES

SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%]

LEFT BELL'S PALSY

CORONARY ANGIOGRAM (04/03/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o Right sided weakness since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 48 years old female patient RAJAMANI came with c/o Right sided weakness since 2 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], LEFT BELL'S PALSY, CORONARY ANGIOGRAM (04/03/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.````````````````````1`
3. TAB. WYSOLONE 20MG 2 TAB ONCE DAILY AT 2PM
4. TAB. SHELICAL-XT ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

54950 rajaiah 61

OBSTRUCTIVE JAUNDICE DUE TO CHOLANGITIS SECONDARY TO
CHOLEDOCHOLELITHIASIS
LEFT PARIETAL WALL LIVER ABSCESS

C/o pain abdomen since 3-4 months,
H/o external abscess in epigastric region

Known case of hypertension

AT ADMISSION:

Afebrile

PR: 78/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 61 years old male patient RAJIAH came with c/o pain abdomen since 3-4 months, h/o external abscess in epigastric region. All necessary investigations were done and diagnosed as OBSTRUCTIVE JAUNDICE DUE TO CHOLANGITIS SECONDARY TO CHOLEDOCHOLELITHIASIS, LEFT PARIETAL WALL LIVER ABSCESS. Managed conservatively. 1 unit of PCV transfusion was done. Patient is being discharged in hemodynamically stable condition. Patient referred to higher centre DR. NAVEEN POLAVARAPU, DEPT OF GASTROENTEROLOGY for further management.

ARH1.00012282
82

Name

Mr.
RAJIAH
PAATI

**Patient
Identifier**

ARHIP54902

Age

63Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

28-Feb-
2022

**Date of
Discharge
MLC No**

Address

1-7
VATIKOLU, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
3

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, IWMI

S/P TLT WITH INJ STK (27/02/22) OUTSIDE

SR, MOERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (03/03/2022) -CAD (Recanalised RCA)

PLAN MEDICAL MANAGEMENT

C/o sudden retrosternal chest pain a/w sweating, nausea, vomiting since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 63 years old male patient Mr. RAJIAH PAATI came with c/o sudden retrosternal chest pain a/w sweating, nausea, vomiting since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, S/P TLT WITH INJ STK (27/02/22) OUTSIDE, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (03/03/2022) -CAD (Recanalised RCA), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012
28333

Name

Mr. BALE
GANGANARS
AIAH

**Patient
Identifier**

ARHIP54920

Age

41Yr
2Mth
3Days

Sex

Male

**Date
of
Admission**

01-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

5-58, DHARUR
JAGTIAL ,Karim
nagar,Telangan
a

**Ward/
Bed
No**

First
Floor,
CICU
, Bed
no:CI
CU9

**Primary
Consultant**

Dr. Vidya Sagar
A--
CARDIOLOGY

CORONARY ARTERY DISEASE, IWMI, NO TLT

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%

R/F: SMOKING, ALCOHOL, T2DM

CORONARY ANGIOGRAM DONE ON 01/03/2022 - CAD-SVD (LCX)

PTCA+DES TO LCX WITH 3V ASTRA 4.0 X 16 MM DONE ON 01/03/2022

C/o chest pain, SOB a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 41 years old male patient Mr. BALE GANGANARSAIAH came with c/o chest pain, SOB a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-38%, R/F: SMOKING, ALCOHOL, T2DM, CORONARY ANGIOGRAM DONE ON 01/03/2022 - CAD-SVD (LCX), PTCA+DES TO LCX WITH 3V ASTRA 4.0 X 16 MM DONE ON 01/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. LIPICURE 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001228 285		Name	Mr. A BHOOAIA H	
Patient Identifier	ARHIP54918	Age	50Yr 0Mth 5Days	
Sex	Male	Date of Admission	01-Mar-2022	
Date of Discharge MLC No				
Address	KARIMNAGAR,Karimnagar,Telangan a	Ward/ Bed No	First Floor, CICU , Bed no:CICU 10	
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE, AWTI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-47%

CORONARY ANGIOGRAM DONE ON 28/02/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3V ASTRA 3.5 X 24 MM DONE ON 03/03/2022

C/o left sided chest pain, radiating to back a/w sweating since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. A BHOOMIAH came with c/o left sided chest pain, radiating to back a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-47%, CORONARY ANGIOGRAM DONE ON 28/02/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3V ASTRA 3.5 X 24 MM DONE ON 03/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TIGATEL-H 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
228035

Name

Mrs.
RAVULA
SUGUNA
MMA

**Patient
Identifier**

ARHIP54891

Age

69
Yr
0M
th
11
Days
26-
Feb-
20
22

Sex

Female

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

CHAMANPALLY,Karimnagar,Telangana

**Ward
/Bed
No**

Second
Floor,
Semi
Private,
Bed
no: 11
9 A

**Primary
Consultant**

Dr. Iftekarali (MS (

INTRACAPSULAR FRACTURE NECK OF FEMUR RIGHT

SURGERY : CEMENTED BIPOLAR HEMIARTHOPLASTY RIGHT HIP DONE ON 01/03/2022

Alleged to have sustained injury to right hip due to slip and fall at home

C/o pain and swelling in right hip.

K/C/O-HTN .

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c
afebrile
PR-98/min
BP-120/80mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-99%

A 69 years old female patient Mrs. RAVULA SUGUNAMMA came with alleged h/o sustained injury to right hip due to slip and fall at home . All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR RIGHT, SURGERY : CEMENTED BIPOLAR HEMIARTHROPLASTY RIGHT HIP DONE ON 01/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

-
1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
 2. TAB: METROGYL 400MG THRICE IN A DAY AT 8AM, 2PM, 8PM FOR 5 DAYS
 3. TAB. TELMISARTAN 40 MG ONE DAILY AT 8AM TO CONTINUE
 4. TAB. VOVERAN SR 75MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
 5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR IFTEKAR ALI SIR OPD.

ARH1.0001
226291

**Na
m
e**

Mr. A
SRINIV
AS

**Patient
Identifier**

ARHIP54948

Age

41Y
r
1Mt
h
27D
ays

Sex

Male

**Date
of
Admi
ssion**

03-
Mar
-
202
2

**Date of
Discharge
MLC No**

Address

JAGITYAL,Karimnagar,
Telangana

**Ward/
Bed
No**

Sec
ond
Flo
or,
Se
mi
Priv
ate,
Bed
no:
103
A

**Primary
Consultan
t**

Dr. GOUTHAM ROY
(MS

LEFT INGUINAL INDIRECT HERNIA
SURGERY: OPEN LEFT INGUINAL HERNIOPLASTY DONE ON 04/03/22

C/o pain in left inguinal region since 1month.

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 41 yrs old male ^{Mr.} SRINIVAS came with c/o pain in left inguinal region since 1 month. All necessary investigations done and diagnosed as LEFT INGUINAL INDIRECT HERNIA, SURGERY: OPEN LEFT INGUINAL HERNIOPLASTY DONE ON 04/03/22. Findings: Indirect sac with the omentum as its contents. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 10 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.000122
8136

Name

Mr. S
JALEN
DER
REDDY

**Patient
Identifier**

ARHIP54936

Age

62Yr
0Mth
9Days

Sex

Male

**Date of
Admission**

02-
Mar-
2022

**Date of
Discharge
MLC No**

Address

NARSAPUR
ELGAID
PEDDAPALLI ,Kari
mnagar,Telangan
a

**Ward/
Bed No**

Seco
nd
Floor
,
Semi
Private,
Bed
no:1
05 B

**Primary
Consultant**

Dr. GOUTHAM
ROY (MS(General

RIGHT INGUINAL DIRECT HERNIA
SURGERY: RIGHT LAP TRANSABDOMINAL PREPERITONEAL MESH REPAIR DONE ON
04/03/22

C/o pain in right inguinal region since 1month.

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c/c

afebrile

PR-81/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-99%

A 62 yrs old male Mr. S JALENDER REDDY came with c/o pain in right inguinal region since 1month. All necessary investigations done and diagnosed as RIGHT INGUINAL DIRECT HERNIA, SURGERY: RIGHT LAP TRANSABDOMINAL PREPERITONEAL MESH REPAIR DONE ON 04/03/22. Findings: Direct defect noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
6. SYP: LACTIHEP 3tsp ONCE DAILY AT 8PM

Review after 10 days in General Surgery OPD.

ARH1.0001228239

Name

Mrs. E
SRILATHA

**Patient
Identifier**

ARHIP54962

Age

33Yr
0Mth
7Days

Sex

Female

**Date of
Admission**

04-
Mar-
2022

**Date of
Discharge
MLC No**

Address

„Karimnagar,Telang
ana

**Ward/
Bed No**

Secon
d
Floor,
Semi
Private
, Bed
no:118
C

**Primary
Consultant**

Dr. GOUTHAM ROY

LEFT BACK LIPOMA
SURGERY: LEFT BACK LIPOMA EXCISION DONE ON 04/03/22

C/o Swelling over left lower back since 1month.

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-99%

A 33 yrs old female Mrs. E SRILATHA came with c/o Swelling over left lower back since 1 month. All necessary investigations done and diagnosed as LEFT BACK LIPOMA, SURGERY: LEFT BACK LIPOMA EXCISION DONE ON 04/03/22.

Findings: Lipoma measuring 4 x 5 cm noted in the left back. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
6. T-BACT OINTMENT FO RL/A

MONITOR VITALS

Review after 10 days in General Surgery OPD.

ARH1.0001228372

Name

Mr. KAVATI
KOMURIAH

**Patient
Identifier**

ARHIP54938

Age

70Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

03-
Mar-
2022

**Date of
Discharge
MLC No**

Address

.,Siddipet,Telangan
a

**Ward/Bed
No**

Secon
d
Floor,
Semi
Private
, Bed
no:122
B

**Primary
Consultant**

DR. NIKHIL GOLI --
NEUROLOGY

TRANSIENT ISCHAEMIC ATTACK

CHRONIC LEFT THALAMIC INFARCT

C/o weakness of left upper limb and lower limb since a few days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 76 years old male patient Mr. KAVATI KOMURIAH came with c/o weakness of left upper limb and lower limb since a few days. All necessary investigations were done and diagnosed as TIA, CHRONIC LEFT THALAMIC INFARCT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE
- 2) TAB. STORVAS 40 MG ONCE DAILY AT 2PM TO CONTINUE
- 3) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE
- 4) TAB. TRYCIT PLUS ONCE DAILY AT 8AM TO CONTINUE
- 5) TAB. REXIPRA 5 MG ONCE DAILY AT 8PM TO CONTINUE

REVIEW AFTER 10 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.00012282
74

Name

Mr.
AMBALA
SAMPATH

**Patient
Identifier**

ARHIP54898

Age

46Yr
0Mth
6Days

Sex

Male

**Date of
Admission**

27-Feb-
2022

**Date of
Discharge
MLC No**

Address

1-106,
KOTHAGATTU, Telangan
a

**Ward/
Bed No**

Second
Floor,
Male
General
Ward,
Bed
no:GW1
6

**Primary
Consultant**

DR. NIKHIL GOLI

ACUTE INTRAPARENCHYMAL BLEED IN RIGHT LENTIFORM NUCLEUS AND CORONA
RADIATA

C/o sudden weakness of left upper limb and lower limb

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. AMBALA SAMPATH came with c/o sudden weakness of left upper limb and lower limb. All necessary investigations were done and diagnosed as ACUTE INTRAPARENCHYMAL BLEED IN RIGHT LENTIFORM NUCLEUS AND CORONA RADIATA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS

2) TAB. NICARDIA RETARD 20 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS IN DR NIKHIL GOLI SIR OPD

ARH1.000122
8374

Name

Mrs. K
RAMAV
VA

**Patient
Identifier**

ARHIP54937

Age

68Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

03-
Mar-
2022

**Date of
Discharge
MLC No**

Address

SIRICILLA,Telang
ana

**Ward/
Bed No**

Seco
nd
Floor
, Semi
Private,
Bed
no:1
18 B

**Primary
Consultant**

Dr.
RAMCHANDER
TORREM

ACUTE KIDNEY INJURY WITH UROSEPSIS

C/o shortness of breath a grade 3 to 4 since few days

Known case of hypertension , diabetic mellitus

AT ADMISSION:

Patient drowsy, oriented

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

TREATED WITH

INJ. MEROFIT PLUS
INJ. IVERTIN
INJ. PANTOCID
TAB. KETO CHECK
TAB. CUDCE FORTE
TAB. ALCYSTA
INJ. PCM
ECONORM SACHETS
NEB WITH DUOLIN BUDECORT
IV FLUIDS NS
INJ. DERIPHYLIN
INJ. HEPARIN
INJ. SODIUM CHLORIDE
THROMBOPHOB OINTMENT

A 68 years old female patient RAMAVVA came with c/o shortness of breath a grade 3 to 4 since few days. Known case of hypertension , diabetic mellitus. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY WITH UROSEPSIS. Managed conservatively. Cardiology consultation was taken and advice followed. Blood culture and urine culture was done, reports are awaited. Sr creatinine 6.0 on 04/03/2022. Patient attendants requested for discharge, patient is being discharged on request.

DISCHARGE MEDICATION:

1. TAB. ROXSAFE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. KETO CHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
4. TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. A TO Z GOLD ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. DYTOR 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. TAB. MONTAIR AB TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
8. TAB. ND Q10 ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS IN NEPHROLOGY OPD

ARH1.000122
7955

Name

Mr.
YELIGETI
RAJESHA
M

**Patient
Identifier**

ARHIP54910

Age

74Yr
4Mth
12Days

Sex

Male

**Date of
Admission**

28-
Feb-
2022

**Date of
Discharge
MLC No**

Address

8-6-21, NEHRU
NAGAR
RAJANNA ,Karimn
agar,Telangana

**Ward/
Bed No**

Seco
nd
Floor
, Male
Gene
ral
Ward
, Bed
no:G
W 21

**Primar
y
Consul
tant**

Dr. SURESH
GOUD S(MS

BENIGN PROSTATIC HYPERTROPHY.
SURGERY: TRANSURETHRAL RESECTION OF PROSTATE DONE ON 03.03.2022

C/o dribbling of urine h/o dysuria

ON ADMISSION

Patient conscious, coherent

Afebrile

PR-84/min

BP-110/70mmhg

RR-21/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-98%

A 74 years old male patient Mr. YELIGETI RAJESHAM presented to hospital with C/o dribbling of urine h/o dysuria . All necessary investigations were done and diagnosed as BENIGN PROSTATIC HYPERTROPHY. Patient underwent surgery of TRANSURETHRAL RESECTION OF PROSTATE DONE ON 03.03.2022. Post operative period was uneventful. Patient discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION

- 1) TAB. ROXSAFE CV TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
- 2) TAB. FAMOCID ONCE DAILY AT 7AM (BEFORE FOOD) FOR 11 DAYS.
- 3) TAB. DOLO 650MG TWICE DAILY AT 8AM AND 8PM FOR 7DAYS.
- 4) TAB. ND Q10 ONCE DAILY AT 2PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO UROLOGY OPD.

54872

A 56years old male patient Mr. SRIPATHI RAO is a presented to hospital with C/o chest pain since 3-4 hours on 25.2.2022. All necessary investigations were done and diagnosed as. CORONARY ARTERY DISEASE POSTERIOR WALL MI.MILD LV DYSFUNCTION, EF-45%.R/F TYPE II DIABETES MELLITUS, HYPERTENSION.CORONARY ANGIOGRAM DONE ON 25/2/2022 CAD DVD (LAD, RCA).PRIMARY PTCA + DES TO RCA WITH XIENCE XPEDITIO 3.5 X 33MM, RCA WITH XIENCE XPEDITIO 3.0 X15MM AND RCA WITH XIENCE XPEDITIO 2.5 X 15MM DONE ON 25/2/2022.Patient was treated with Antiplatelet, Anticoagulants, Antacids and other supportive measures. Neuro Physician Consultation was taken and advised followed, Urologist consultation was taken and advised followed, Neurosurgeon Consultation was taken and advised followed. Patient is Symptomatically Now patient is being discharged in hemodynamically stable condition with required medication and advice.
DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BRLINTA 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 9PM TO CONTINUE.
- 4) TAB. TOLMOV .150 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARDACE-H 5 MG ONCE DAILY AT 9PM TO CONTINUE.
- 6) TAB. VELOZ IT ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. MAXMALA FORTE ONCE DAILY AT 9PM TO CONTINUE.
- 8) TAB. DAPARY 10 MG ONCE DAILY BEFORE LUNCH TO CONTINUE.
- 9) INJ. LANTUS 30 U ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIOLOGY OPD WITH FBS/PLBS REPORT

REVIEW AFTER 1 MONTH TO UROLOGY OPD WITH CECT ABDOMEN

ARH1.000122
7624

Name

Mr. P
KOMURAI
AH

**Patient
Identifier**

ARHIP54781

Age

60Yr
0Mth
23Days

Sex

Male

**Date of
Admission**

18-
Feb-
2022

**Date of
Discharge
MLC No**

Address

„Bejjanki,Telanga
na

**Ward/
Bed No**

First
Floor
, CT
POST
, Bed
no:CT
2

**Primary
Consultant**

Dr
SOMASHEKAR
K(

SURGERY -CORONARY ARTERY BYPASS GRAFTING SVG to dRCA DONE ON
28/02/2022.

CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+LV DYSFUNCTION
+AWMI

C/o chest pain a/w SOB since 3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old male patient Mr. KOMURIAH presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CAD+DVD+LV DYSFUNCTION +AWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING SVG to dRCA DONE ON 28/02/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, MODERATE LV DYSFUNCTION, EF-40%, MILD TR /PAH. NO PE/CLOT/VEG

BMI is 17.4 kg/m².

Sr. Creatinine report on 01.03.2022 1.1 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 9) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001228415		Name	Mr. MIRZA KHAJA PASHA BEG
Patient Identifier	ARHIP54955	Age	54Yr 0Mth 2Days
Sex	Male	Date of Admission	04-Mar-2022
Date of Discharge			
MLC No			
Address	PEDDAPALLI ,Karimnagar,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MICU 10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI, NO TLT SR, SEVERE LV DYSFUNCTION [EF-30%]

R/F : SMOKING, HYPERTENSION, TYPE-II DIABETES MELLITUS
CORONARY ANGIOGRAM (04/03/2022) -CAD-TVD (LAD, LCX, RCA)

ADV: CABG

C/o chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 54 years old male patient Mr. MIRZA KHAJA PASHA BEG came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NO TLT, SR, SEVERE LV DYSFUNCTION [EF-30%], R/F : SMOKING, HYPERTENSION, TYPE-II DIABETES MELLITUS, CORONARY ANGIOGRAM (04/03/2022) - CAD-TVD (LAD, LCX, RCA), ADV: CABG. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TELVAS+BETA 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLYCOMET SR 500MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

.000122
8471

Name

Mr.
VIJA
Y
KUM
AR

**Patient
Identifier**

ARHIP54972

Age

51
Yr
0M
th
0D
ays
05-
Mar-
20
22

Sex

Male

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

GANESHNAGAR,Karimnagar,T
elangana

**Ward/
Bed
No**

Firs
t
Flo
or,
Da
y
Car
e,
Be
d
no:
DC
2

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, RBBB, MILD AS, SR
NORMAL LV SYSTOLIC FUNCTION [EF-60%]

R/F : T2DM, HTN

CORONARY ANGIOGRAM (05/03/2022) -CAD-SVD (LAD)

PLAN MEDICAL MANAGEMENT FOR DIAGONAL (THIN VESSEL)

C/o chest pain since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 51 years old male patient Mr. VIJAY KUMAR came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, RBBB, MILD AS, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], R/F : T2DM, HTN , CORONARY ANGIOGRAM (05/03/2022) -CAD-SVD (LAD) , PLAN MEDICAL MANAGEMENT FOR DIAGONAL (THIN VESSEL). Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. GLYCOMET GP1 TWICE DAILY AT 8AM 8PM TO CONTINUE.
2. TAB. ENCLIN M SR 500 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. SARTEL CT 80/12.5 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. EMBETA XR 25 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.

7. TAB. ROSEDAY 40 MG ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00010
37068

Name

Mr.
MAHAM
MAD
DASTHA
GIRI

**Patient
Identifier**

ARHIP54811

Age

62Yr
11M
th
27D
ays

Sex

Male

**Date
of
Admission**

21-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

1-156, PATHAGUDUR,
VELGATUR,,Karimnagar
,Andhra Pradesh

**Ward/
Bed
No**

First
Floor,
CT
POST,
Bed
no:
CT 4

**Primary
Consultant**

Dr SOMASHEKAR K

SURGERY -CORONARY ARTERY BYPASS GRAFTING SVG to LAD, OM DONE ON
01/03/2022

CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+MODERATE LV
DYSFUNCTION +S/P AWTMI

C/o chest pain a/w SOB since 2 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 62 years old male patient Mr. MAHAMMAD DASTHAGIRI presented to hospital with c/o chest pain a/w SOB since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+MODERATE LV DYSFUNCTION +S/P AWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING SVG to LAD, OM DONE ON 01/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, EF-50%, MILD AR/MR/PAH. NO PE/CLOT/VEG

BMI is 17.9 kg/m².

Sr. Creatinine report on 02.03.2022 0.8 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 2 DAYS
- 6) TAB. DOLO 650 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS

7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

9) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001228
516

Name

Mr. A
KUMA
RA
SWAM
Y

**Patient
Identifier**

ARHIP54980

Age

34Yr
0Mt
h
1Da
ys

Sex

Male

**Date of
Admission**

06-
Mar-
202
2

**Date of
Discharge
MLC No**

Address

PEDDAPALLI ,Kari
mnagar,Telangan
a

**Ward/
Bed No**

First
Floor,
Day
Care,
Bed
no:
DC
2

**Primary
Consultant**

Dr. Vidya Sagar
A--CARDIOLOGY

ATYPICAL CHEST PAIN,
SR, NORMAL LV SYSTOLIC FUNCTION
R/F: HYPERTENSION, SMOKING, ALCOHOL
CORONARY ANGIOGRAM (04/03/2022) - NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o Retrosternal chest pain, on and off since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 34 years old male patient Mr. A KUMARA SWAMY came with c/o retrosternal chest pain, on and off since 1 month. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, R/F: HYPERTENSION, SMOKING, ALCOHOL, CORONARY ANGIOGRAM (04/03/2022) - NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELMA-CT 40/12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. STAMLO 5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID-DSR 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
6. QUIT SMOKING & ALCOHOL

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001228409		Name	Mr. NARAYAN CHANDRA MANDAL
Patient Identifier	ARHIP54952...	Age	77Yr 4Mth 23Days
Sex	Male	Date of Admission	03-Mar-2022
Date of Discharge MLC No			
Address	SIRPUR KAGAZ NAGAR,Asifabad,Telangan a	Ward/ Bed No	First Floor, CICU , Bed no:CICU1 3
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF:40%

R/F: T2DM, HTN

CORONARY ANGIOGRAM DONE ON 03/03/2022 - CAD-DVD (LAD, LCX)

PRIMARY PTCA+DES TO LCX WITH 3.0 X 18 MM XIENCE XPEDITION AND LAD WITH 2.75 X 28 MM XIENCE XPEDITION DONE ON 03/03/2022

C/o chest pain a/w sweating since 2 days

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 77 years old male patient Mr. NARAYAN CHANDRA MANDAL came with c/o chest pain a/w sweating since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF:40%, R/F: T2DM, HTN, CORONARY ANGIOGRAM DONE ON 03/03/2022 - CAD-DVD (LAD, LCX), PRIMARY PTCA+DES TO LCX WITH 3.0 X 18 MM XIENCE XPEDITION, LAD WITH 2.75 X 28 MM XIENCE XPEDITION DONE ON 03/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BRILLINTA 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. CARDACE 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
203004

Name

Mr.
MA
LLA
RE
DD
Y B

**Patie
nt
Identi
fier**

ARHIP54957

Age

56
Yr
2M
th
2D
ays
04-
Ma
r-
20
22

Sex

Male

**Date
of
Admi
ssion**

**Date
of
Disch
arge
MLC
No**

**Addr
ess**

gangipelli,manakondur,Karim
nagar,Telangana

**Ward
/Bed
No**

Sec
on
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Flo
or,
Se
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11
7 A

**Prima
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Cons
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t**

Dr Chandra Shekar
Sathineni(MD (Internal

ACUTE FEBRILE ILLNESS

HYPERTENSION

c/o fever since 3-4 days a/w headache and neck pain

AT ADMISSION:

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 56 years old male patient Mr. MALLA REDDY B came with c/o fever since 3-4 days a/w headache and neck pain. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. FPM-ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. TAZOLAC CT ONCE DAILY AT 8AM FOR 15 DAYS
- 4) TAB. GLUCO Q10 ONCE DAILY AT 2PM FOR 15 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.00012283
59

Name

Mr.
RAMULU E

Patient Identifier

ARHIP54930

Age

39Yr
0Mth
5Days

Sex

Male

Date of Admission

02-Mar-2022

**Date of Discharge
MLC No**

Address

4-2/1 ST COLONY
KOMARAM
BHEEM,Karimnagar,Telangan
a

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
2

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE -ALWMI
THROMBOLISATION WITH INJ. TENECTEPLASE (01/03/22) OUTSIDE
SR, MILD LV SYSTOLIC DYSFUNCTION, EF- 55%
CORONARY ANGIOGRAM DONE ON 04/03/2022 - CAD-SVD (RAMUS)

PTCA+DES TO RAMUS WITH 3.0 X 13 MM METAFOR DONE ON 04/03/2022

C/o sudden left sided chest pain a/w SOB since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 39 years old male patient Mr. RAMULU came with c/o sudden left sided chest pain a/w SOB since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE -ALWMI THROMBOLISATION WITH INJ. TENECTEPLASE (01/03/22) OUTSIDE, SR, MILD LV SYSTOLIC DYSFUNCTION, EF- 55% CORONARY ANGIOGRAM DONE ON 04/03/2022 - CAD-SVD (RAMUS), PTCA+DES TO RAMUS WITH 3.0 X 13 MM METAFOR DONE ON 04/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET-R 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012283
68

Name

Mr.
MUNAIAH
POTHEM

**Patient
Identifier**

ARHIP54932

Age

62Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

02-
Mar-
2022

**Date of
Discharge
MLC No**

Address

5-6, NANDAGIRI
JAGTIAL, Karimnagar, Telanga
na

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 5

**Primary
Consultant**

Dr. Vidya Sagar A-

CORONARY ARTERY DISEASE, NSTEMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 45%

R/F: SMOKING, HYPERTENSION

CORONARY ANGIOGRAM DONE ON 04/03/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.5 X 44 MM METAFOR DONE ON 04/03/2022

C/o SOB on exertion, chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 62years old male patient Mr. MUNAIAH POTHEM came with c/o SOB on exertion, chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 45%, R/F: SMOKING, HYPERTENSION, CORONARY ANGIOGRAM DONE ON 04/03/2022 – CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.5 X 44 MM METAFOR DONE ON 04/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
28430

Name

Mr.
SUNDHARA
GIRI
RAJAIAH

**Patient
Identifier**

ARHIP54958

Age

77Yr
2Mth
3Days

Sex

Male

**Date
of
Admission**

04-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

4-10,
NAGASAMUD
RAM
MANCHERIAL
7337227018
,Telangana

**Ward/
Bed
No**

First
Floor,
CICU
, Bed
no:CI
CU2

**Primary
Consultant**

Dr. Vidya
Sagar A

CORONARY ARTERY DISEASE, AWM

SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%]

CORONARY ANGIOGRAM (04/03/2022) - CAD -RECANALISED LAD
PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 77 years old male patient Mr. SUNDHARAGIRI RAJAIAH came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM (04/03/2022) - CAD - RECANALISED LAD, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. STAMLO 5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. NIKORAN 5MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000122834
4

Name

Mrs. AITHA
MANEMMA

**Patient
Identifier**

ARHIP54922

Age

70Yr
2Mth
6Days

Sex

Female

**Date of
Admission**

01-Mar-
2022

**Date of
Discharge
MLC No**

Address

1-34
RANGAPETTA ,Karim
nagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
7

**Primary
Consultant**

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE, ACUTE AWMI

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: TOBACCO ADDICT, HYPERTENSION

CORONARY ANGIOGRAM DONE ON 01/03/2022 – CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR DONE ON 01/03/2022
RIGHT FEMORAL PSEUDOANEURYSM (COMPRESSION DONE)

C/o sudden onset of chest pain, radiating to back

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70 years old female patient Mrs. AITHA MANEMMA came with c/o sudden onset of chest pain, radiating to back . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: TOBACCO ADDICT, HYPERTENSION, CORONARY ANGIOGRAM DONE ON 01/03/2022 – CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 3.0 X 37 MM METAFOR DONE ON 01/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CILODOC 50MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TONACT 40 MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. CARDORONE-X 200 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 7) TAB. CHYMORAL FORTE TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001228
417

**Na
me**

Mr. BASU
MOHAMMA
D

**Patient
Identifier**

ARHIP54953

Age

45Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

03-Mar-
2022

**Date of
Discharge
MLC No**

Address

5-7
KALLEDA, Karimnagar, Telan
gana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
8

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE AWM

SEVERE LV DYSFUNCTION, EF-25%

R/F HTN, TOBACCO

S/P CORONARY ANGIOGRAM DONE ON 04/03/2022 - CAD-DVD (LAD, RCA)

PLAN CABG.

C/o Retrosternal chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 80/min

BP: 150/100 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 45 years old male patient Mr. BASU MOHAMMAD came with c/o retrosternal chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AAWMI, SEVERE LV DYSFUNCTION, EF-25%, R/F HTN, TOBACCO, S/P CORONARY ANGIOGRAM DONE ON 04/03/2022 - CAD-DVD (LAD, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
4. TAB. CARDACE 3.125 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. TAB. RAMISTAR 2.5 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.00
0121818
2

Name

Mr.
NAZEE
BUDDI
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MOHA
MMAD

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ARHIP54923

Age

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Sex

Male

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**Add
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7-7-209/
SC,MAHALAXMINAGAR,JAGTI
AL,Telangana

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Bed
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Dr. Iftekarali (MS
(Orthopaedics)

PROXIMAL END OF HUMERUS FRACTURE LEFT

SURGERY: ORIF WITH PROXIMAL HUMERUS LOCKING PLATE DONE ON 03/03/22

Alleged history of sustained injury due to slip and fall from 2 wheeler himself on 24-02-22 around 7 p.m.

C/o pain and swelling in left shoulder .

K/C/O-HTN, T2DM

S/P PTCA in July 2021.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-98/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-99%

A 33 years old male patient Mr. NAZEEBUDDIN MOHAMMAD came with alleged history of sustained injury due to slip and fall from 2 wheeler himself on 24-02-22 around 7 p.m. c/o pain and swelling in left shoulder. All necessary investigations were done and diagnosed as PROXIMAL END OF HUMERUS FRACTURE LEFT, SURGERY: ORIF WITH PROXIMAL HUMERUS LOCKING PLATE DONE ON 03/03/22. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
2. TAB: METROGYL 400MG THRICE IN A DAY AT 8AM, 2PM, 8PM FOR 5 DAYS
3. TAB. VOVERAN SR 75MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO DR IFTEKAR ALI SIR OPD.

ARH1.00012
28277

Name

Mrs.
RUKKA
MMA
KOLAGA
NI

**Patient
Identifier**

ARHIP54897

Age

78Yr
0Mth
8Days

Sex

Female

**Date
of
Admission**

27-
Feb-
202
2

**Date
of
Discharge
MLC
No**

Address

3-12,
TEEGALAGUTTAP
ALLY ,Karimnaga
r,Telangana

**Ward/
Bed
No**

Sec
ond
Floor,
Female
General
Ward,
Bed
no:G
W 9

**Primary
Consultant**

DR. SANJAY
KUMAR
KAMINWAR

RIGHT PONTINE INFARCT

Weakness of left upper limb and lower limb, slurring of speech
Known case of hypertension and hypothyroidism

AT ADMISSION:

Patient drowsy

PR: 106/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 78 years old female patient Mrs. RUKKAMMA KOLAGANI came with c/o weakness of left upper limb and lower limb, slurring of speech, Known case of hypertension and hypothyroidism. All necessary investigations were done and diagnosed as RIGHT PONTINE INFARCT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: COLTRO 10MG ONCE DAILY AT 8PM FOR 11DAYS.
2. TAB. PREVA AS 75MG ONCE DAILY AT 2PM FOR 11DAYS.
3. TAB. THYRONORM 100MCG ONCE DAILY AT 7AM FOR 11DAYS.

REVIEW AFTER 11DAYS IN DR. SANJAYKUMAR sir OPD.

ARH1.00012284
25

Name

Mrs. K
RAMANAIA
H

**Patient
Identifier**

ARHIP54960

Age

60Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

04-Mar-
2022

**Date of
Discharge
MLC No**

Address

SHIVAJI
NAGAR, Karimnagar, Telang
ana

**Ward/Bed
No**

First
Floor,
SICU,
Bed
no: SIC
U 1

**Primary
Consultant**

DR. SUBRAT KUMAR SOREN
--NEUROSURGERY

SEVERE TRAUMATIC BRAIN INJURY
TRANSTENTORIAL HERNIATION
ACUTE SUBDURAL HAEMORRHAGE
DIFFUSE SUBARACHNOID HAEMORRHAGE
SKULL BASE FRACTURE
BRAINSTEM HAEMORRHAGE
ABSENT BRAINSTEM REFLEX

Alleged history of fall from height at home half an hour back on 04/03/22 and sustained injury to head and chest. Patient brought to Emergency Room in unconscious state, not breathing for 15-20 minutes

AT ADMISSION:

Patient unconscious

PR: 97/min

BP: 70/50mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100% FIO2

P/A: Soft

GCS-E1 V1 M1, Mid pupil dilated and fixed

A 60 years old male patient Mrs. K RAMANAIAH came with alleged history of fall from height at home half an hour back on 04/03/22 and sustained injury to head and chest. Patient brought to Emergency Room in unconscious state, not breathing for 15-20 minutes. All necessary investigations were done and diagnosed as SEVERE TRAUMATIC BRAIN INJURY, TRANSTENTORIAL HERNIATION , ACUTE SUBDURAL HAEMORRHAGE, DIFFUSE SUBARACHNOID , HAEMORRHAGE, SKULL BASE FRACTURE, BRAINSTEM HAEMORRHAGE , ABSENT BRAINSTEM REFLEX . Resuscitation done as per ACLS protocol, intubation was done in view of poor GCS and threatened airway. On 07/03/2022 at 2.30 p.m. patient had cardiac arrest , informed to patient attendants. Pupils dilated and fixed, ECG showed asystole, hence declared dead at 02.35 PM on 07/03/2022.

CAUSE OF DEATH

HEAD INJURY, ACUTE SUBDURAL HAEMORRHAGE, DIFFUSE SUBARACHNOID HAEMORRHAGE, BRAINSTEM HAEMORRHAGE

ARH1.00012284
34

Name

Mrs.
NAGARTHI
SAVITHRI

**Patient
Identifier**

ARHIP54965

Age

61Yr
2Mth
3Days

Sex

Female

**Date of
Admission**

04-Mar-
2022

**Date of
Discharge
MLC No**

Address

1-83, RAMESHWAR
PALLY
KAMAREDDY ,Karim
nagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
3

**Primary
Consultant**

Dr. Vidya Sagar A--

ATYPICAL CHEST PAIN
MILD MR, MILD PAH, SR
NORMAL LV SYSTOLIC FUNCTION, EF-55%
R/F : HYPERTENSION
CORONARY ANGIOGRAM (07/03/2022) - NORMAL EPICARDIAL
CORONARIES
PLAN MEDICAL MANAGEMENT

Patient can undergo knee replacement under low risk

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 61 years old female patient Mrs. NAGARTHI SAVITHRI came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN MILD MR, MILD PAH, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, R/F : HYPERTENSION, CORONARY ANGIOGRAM (07/03/2022) - NORMAL EPICARDIAL CORONARIES, PLAN MEDICAL MANAGEMENT, PATIENT CAN UNDERGO KNEE REPLACEMENT UNDER LOW RISK. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. PROLOMET-R 25 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. RANTAC 150 MG TWICE DAILY AT 8AM 8PM FOR 10 DAYS
3. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001
219076

Name

Mr.
DUR
GAM
CHAN
DRA
REDD
Y

**Patient
Identifier**

ARHIP54946

Age

44Yr
7Mth
0Days

Sex

Male

**Date
of
Admission**

03-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

KONDAPUR,
RAJANNASIRICILLA, Karimnagar,
Telangana

**Ward/
Bed
No**

First
Floor,
CICU,
Bed
no: CICU1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

OLD CAD, S/P PTCA+DES TO LCS (11/08/2021)

CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-LCX stent mild instent restenosis

PLAN MEDICAL MANAGEMENT

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 44years old male patient Mr. DURGAM CHANDRA REDDY came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, OLD CAD, S/P PTCA+DES TO LCS (11/08/2021), CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-LCX stent mild instent restenosis, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. STARPRESS XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) CAP. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001
228103

Name

Mr.
NADIG
OTTU
KOMUR
AIAH

**Patient
Identifier**

ARHIP54851

Age

48Y
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3Mth
12D
ays
24-
Feb
-
202
2

Sex

Male

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

13-72/1
MANAKONDUR,Karimnagar,
Telangana

**Ward/
Bed
No**

Firs
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Floor,
MIC
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Bed
no:
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**Primary
Consultant
Surgeons**

DR. NIKHIL GOLI --
NEUROLOGY

Consultants

C/o right sided weakness, associated with slurring of speech since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 48 years old male patient KOMURIAH came with c/o right sided weakness, associated with slurring of speech since 2 days. All necessary investigations were done and diagnosed as MULTIPLE TERRITORY INFARCTS, ? CARDIOEMBOLISM. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2 PM FOR 10 DAYS
- 2) TAB. STORVAS 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 3) TAB. SARTEL 20 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 4) TAB. SUPRADYN ONCE DAILY AT 8AM FOR 10 DAYS

REVIEW AFTER 10 DAYS IN DR NIKHIL GOLI SIR OPD

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1228245

Name

Mr.
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ARHIP54888

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Sex

Male

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Dr. RAMCHANDER
TORREM(MD (General

URINARY TRACT INFECTION
CHRONIC KIDNEY DISEASE

C/o Swelling of feet since 15 days

Known case of hypertension, renal stone, osteoarthritis of bilateral knee

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

P/A: Soft

A 83 years old male patient Mr. RAZZAB ALI came with c/o Swelling of feet since 15 days. Known case of hypertension, renal stone, osteoarthritis of bilateral knee. All necessary investigations were done and diagnosed as URINARY TRACT INFECTION, CHRONIC KIDNEY DISEASE. Managed conservatively. 1 unit of PCV transfusion given. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. SALTED BUTTERMILK THRICE DAILY 8AM 2PM AND 8PM TO CONTINUE.
3. TAB. AZOVAS 16 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. THYRONORM 25 MCG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. KETO CHECK THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
6. TAB. CUDCE FORTE THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
7. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
8. TAB. DYTOR PLUS TWICE DAILY AT 8AM AND 8PM TO CONTINUE
9. SYP. POTKLOR 15 ml ONCE DAILY AT 8PM

REVIEW AFTER 5 DAYS TO NEPHROLOGY OPD

ARH1.0001
228414

Name

Mr.
B
LAX
MAN

Patient Identifier

ARHIP54954

Age

58Yr
0Mth
5Days

Sex

Male

Date of Admission

03-
Mar-
2022

**Date of Discharge
MLC No**

Address

VELGONDA
JAGITIAL ,Kari
mnagar,Telan
gana

**Ward/
Bed No**

First
Floor
,
CICU
, Bed
no:CI
CU2

Primary Consultant

Dr. Vidya
Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE- NON-ST ELEVATION
SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%

RISK FACTOR: T2DM, HTN

CORONARY ANGIOGRAM DONE ON 05/03/2022 - CAD-SVD (RCA)

PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY +DES TO RCA WITH 3V
ASTRA 3.0 X 24 MM DONE ON 05/03/2022

C/o chest pain since 1 days a/w 1 episode of vomiting

AT ADMISSION:

Afebrile

PR: 92/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. B LAXMAN came with c/o chest pain since 1 days a/w 1 episode of vomiting. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- NON-ST ELEVATION, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, RISK FACTOR: T2DM, HTN, CORONARY ANGIOGRAM DONE ON 05/03/2022 – CAD-SVD (RCA), PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY +DES TO RCA WITH 3V ASTRA 3.0 X 24 MM DONE ON 05/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELLZY 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. GLYCOMET-GP1 FORTE ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APJ1.00021
80213

**Na
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Mr.
KALYANAM
JAGANNAT
HAM

**Patient
Identifier**

ARHIP54942

Age

59Y
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9Mt
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5Da
ys

Sex

Male

**Date of
Admissio
n**

03-
Mar-
202
2

**Date of
Discharg
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MLC No**

Address

HNO 3-17, JAWAHAR
NAGAR,
SULTHANABAD,,Hyderabad,
Telangana

**Ward/
Bed No**

Sec
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Bed
no:1
03
C

**Primary
Consulta
nt**

DR. SRI KARAN UDDESH

URINARY TRACT INFECTION
UNCONTROLLED DIABETES MELLITUS
ASYMPTOMATIC HYPONATRAEMIA

C/o Fever and dysuria since 3 days

Known case of hypertension and diabetes mellitus

AT ADMISSION:

PR: 91/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 59 years old male patient Mr. KALYANAM JAGANNATHAM came with dysuria and fever since 3 days, Known case of hypertension and diabetes mellitus. He is treated with INJ. CEFTAZIDIME, INJ. TAZOBACTAM, INJ. DOXY and other supportive medication. Patient improved gradually. His diabetes treated with INJ. HUMAN ACTRAPID and INJ. LANTUS. Patient is afebrile and haemodynamically stable and discharged with required medication.

DISCHARGE MEDICATION:

- 1) TAB. LEVOFLOXACILLIN 500 MG TWICE DAILY AT 8AM AND 8PM FOR 3 DAYS
- 2) TAB. VILDA-M (10/500) ONCE DAILY AT 8AM TO CONTINUE
- 3) INJ. APIDRA 10 UNITS BEFORE BREAKFAST, 8 UNITS BEFORE LUNCH, 6 UNITS BEFORE DINNER TO CONTINUE
- 4) INJ. LANTUS 20 UNITS S/C ONCE DAILY AT 8 PM TO CONTINUE

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.000
1228259

Name

Mr. M
SHASHI
KANTH

**Pati
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Iden
tifier**

ARHIP54893

Age

37
Yr
0M
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10
Da
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27-
Feb
-
20
22

Sex

Male

**Date of
Admissio
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**Date
of
Disc
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MLC
No
Addr
ess**

27-Feb-2022

RAJANNA
SIRCILLA ,Ka
rimnagar,Tel
angana

**Ward/
Bed No**

Firs
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Flo
or,
MI
CU,
Be

**Prim
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Cons
ulta
nt**

Dr. Vidya
Sagar A--
CARDIOLOG
Y

**Consulta
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**Surg
eons**

Dr. Vidya
Sagar A--
CARDIOLOG
Y

**Anesthes
iologists**

Diagnosi
S

Diagnosis

Disease	Disease Type
ATYPICAL CHEST PAIN WITH ECG CHANGES , MILD MR SR, NORMAL LV SYSTOLIC FUNCTION EF-60% RISK FACTOR DENOVO HYPERTENSION, CORONARY ANGIOGRAM(27/2/2022)NORMAL CORONARIES LEFT DOMINANT SYSTEM. ADVICE.MEDICAL MANAGEMENT	

C/o chest pain gradual onset radiating to back, pricking type since 1 to 2 months on and off, associated with sweatings.

Denovo Hypertension

ADMISSION VITALS:

Patient conscious,coherent

Afebrile

PR:88/min

BP:120/70mmhg

RS:BAE+

CVS:S1S2

RR:20/min

SPO2:96%

P/A-soft

A 37 years old male patient Mr. SHASHIKANTH came with c/o chest pain gradual onset radiating to back, pricking type since 1 to 2 months on and off, associated with sweatings. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN WITH ECG CHANGES , MILD MR SR, NORMAL LV SYSTOLIC FUNCTION EF-60%, RISK FACTOR : DENOVO HYPERTENSION, CORONARY ANGIOGRAM(27/2/2022) - NORMAL CORONARIES - LEFT DOMINANT SYSTEM. ADVICE: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 9PM TO CONTINUE.
4. TAB. LIPRIL 5 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.000115 5099		Name	Mr. VELAMA SUDHAK AR RAO	
Patient Identifier	ARHIP54944	Age		74Yr 4Mt h 21D ays
Sex	Male	Date of Admission		03- Mar- 202 2
Date of Discharge MLC No				
Address	SSC RESIDENCIAL, NEAR GEETHA BHAVAN, KARIMNAGAR, Karimnagar, Telangana	Ward/ Bed No		Seco nd Floor , Singl e Room, Bed no:1 14
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

ATYPICAL CHEST PAIN
 SEVERE MR, MODERATE TR, PAH
 MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%
 RISK FACTOR: TYPE-II DIABETIC MELLITUS, HYPERTENSION
 S/P PPI (DDDR 27/02/2004)
 PG INTEROGATION (07/03/2022) LONGEVITY 8-9 HR VVIR MODE
 CKD

C/o exertional dyspnoea
 Patient came for calibration/ recalibration of PPI /PG, SJ. JUDE'S
 PPI done in 2004
 S/P PG change done in 2014, last calibration done in 2019

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 70/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 74 years old male patient Mr. VELAMA SUDHAKAR RAO c/o exertional dyspnoea, came for calibration/ recalibration of PPI /PG, SJ. JUDE'S, PPI done in 2004, S/P PG change done in 2014, last calibration done in 2019. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SEVERE MR, MODERATE TR, PAH , MODERATE LV SYSTOLIC DYSFUNCTION, EF-40% , RISK FACTOR: TYPE-II DIABETIC MELLITUS, HYPERTENSION, S/P PPI (DDDR 27/02/2004), PG INTEROGATION (07/03/2022) LONGEVITY 8-9 HR VVIR MODE, CKD. Nephrologist consultation taken in view of renal disease, Physician consultation taken in view of diabetes and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATENOLOL 25 MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RABIUM 10 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. DAPIFY 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. SOBINIX DS ONCE DAILY AT 8AM TO CONTINUE.

8. TAB. KETOCHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 1 WEEK WITH FBS, PLBS, CBP & RP2 REPORTS WITH
DR VIDYASAGAR
DR CHANDRASHEKAR
DR RAMCHANDER

ARH1.00012 28464		Name	Mr. MOHMA D SHAFIUD DIN
Patient Identifier	ARHIP54968	Age	48Yr 0Mth 4Days
Sex	Male	Date of Admission	04- Mar- 2022
Date of Discharge MLC No			
Address	6-3-317, SUBASHNAGAR,Karimnagar, Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CI CU4
Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE, ANTERIOR WALL MI (DAY 2)
SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 35%

RISK FACTOR: T2DM, SMOKING, ALCOHOL

CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN CABG

C/o left sided chest pain since 3 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 48 years old male patient MOHMAD SHAFIUDDIN came with c/o left sided chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MI (DAY 2), SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF- 35%, RISK FACTOR: T2DM, SMOKING, ALCOHOL, CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-TVD (LAD, LCX, RCA). PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
5. TAB. METADOZE IPR 850 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS/PLBS REPORTS

ARH1.00
012284
93

**N
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Mr.
MUKT
AVAR
AM
VENU
GOPAL

**Patient
Identifier**

ARHIP54973

Age

51
Yr
2M
th
3D
ays

Sex

Male

**Date
of
Admission**

05-
Mar-
20
22

**Date
of
Discharge
MLC
No**

Address

CREDITCELL_KRMNGR@APOLLOHOSPITALS
.COM,Karimnagar,Telangana

**Ward
/Bed
No**

Fir
st
Floor,
CI
CU
,
Bed
no:
CI
CU
8

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE- ANTERIOR WALL MI, NO THROMBOLISATION, SR
SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
CORONARY ANGIOGRAM DONE ON 05/03/2022 - CAD-SVD (LAD)
PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY +DES TO LAD WITH
METAFOR 3.0 X 19 MM DONE ON 05/03/2022
DENOVO DIABETIC MELLITUS

C/o retrosternal chest pain a/w SOB since 2 days

AT ADMISSION:

Afebrile

PR: 103/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 51 years old male patient Mr. MUKTAVARAM VENU GOPAL came with c/o retrosternal chest pain a/w SOB since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- ANTERIOR WALL MI, NO THROMBOLISATION, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 05/03/2022 - CAD-SVD (LAD), PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY +DES TO LAD WITH METAFOR 3.0 X 19 MM DONE ON 05/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) INJ HUMAN MIXTURED 30/70 20 Units S/C AT 8AM, 10 Units AT 8PM CONTINUE

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012282
84

Name

Ms.
PADMA
SAMALA

Patient Identifier

ARHIP54904

Age

61Yr
2Mth
7Days

Sex

Female

Date of Admission

28-Feb-
2022

**Date of Discharge
MLC No**

Address

RAMAGUNDEM
, Karimnagar,
Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no:SIC
U 2

Primary Consultant

DR. SUBRAT
KUMAR SOREN

LEFT CAPSULOGANGLIONIC BLEED WITH MASS EFFECT
SURGERY: LEFT FRONTOTEMPORO PARIETAL DECOMPRESSIVE CRANIECTOMY DONE
ON 28/02/2022

C/o Weakness of right upper limb and lower limb since 27-02-22

AT ADMISSION:

Patient drowsy, responding to deep pain stimulus
GCS E2 V1 M5
PR: 96/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 61 years old female patient Ms. PADMA SAMALA came with c/o weakness of right upper limb and lower limb since 27-02-22. All necessary investigations were done and diagnosed as LEFT CAPSULOGANGLIONIC BLEED WITH MASS EFFECT, SURGERY: LEFT FRONTOTEMPORO PARIETAL DECOMPRESSIVE CRANIECTOMY DONE ON 28/02/2022. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
2. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
3. SYP. DUPHALAC 15 ml ONCE DAILY AT 8PM TO CONTINUE
4. TAB. AUGMENTIN DUO TWICE DAILY AT 8AM AND 8PM TO CONTINUE
5. TAB. REJUNEX ONCE DAILY AT 8AM TO CONTINUE
6. TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

ACTIVE PHYSIOTHERAPY TO CONTINUE

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.00012
28520

**Na
me**

Mr.
ELLAIAH
BODDUP
ALLI

**Patient
Identifier**

ARHIP54982

Age

82Yr
0Mth
7Day
s

Sex

Male

**Date of
Admissi
on**

06-
Mar-
2022

**Date of
Discharge
MLC No**

Address

NTPC
RAMAGUNDEM,Karimnagar,
Telangana

**Ward/
Bed No**

First
Floor
,
MICU
, Bed
no:MI
CU
12

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

ADHF [ACUTE PULMONARY EDEMA]
CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR
MODERATE LV SYSTOLIC DYSFUNCTION EF 30%
SEVERE MR, MILD TR, PAH
S/P CABG
S/P BILATERAL TKR
RISK FACTORS : HYPERTENSION, DIABETES MELLITUS

C/o Chest pain associated with palpitations shortness of breath since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 82 years old male patient Mr. ELLAIAH BODDUPALLI came with c/o Chest pain associated with palpitations shortness of breath since 1 day. All necessary investigations were done and diagnosed as ADHF [ACUTE PULMONARY EDEMA], CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MODERATE LV SYSTOLIC DYSFUNCTION EF 30% , SEVERE MR, MILD TR, PAH, S/P CABG, S/P BILATERAL TKR , RISK FACTORS : HYPERTENSION, DIABETES MELLITUS. Managed conservatively. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CONCOR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. VALEMBIC 80 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. RECLIDE MR 30 MG ONCE DAILY AT 8PM TO CONTINUE.
8. TAB. PANTOCID 40 MG ONCE DAILY AT 7AM TO CONTINUE.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

ARH1.00012
28244

**Na
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Mr.
MALLAIAH V

**Patient
Identifier**

ARHIP54890

Age

63Y
r
0Mt
h
11D
ays
26-
Feb-
202
2

Sex

Male

**Date of
Admission**

**Date of
Discharge
MLC No**

27-Feb-2022

Address

GEELAKUNTA, ODELA,
PEDDAPALLI, Karimnagar,
Telangana

**Ward/Bed
No**

First
Floo
r,
Day
Car
e,
Bed
no:
DC
3

**Primary
Consultan
t**

Dr. Vidya Sagar A--
CARDIOLOGY

**Consultant
s**

Surgeons

Dr. Vidya Sagar A--
CARDIOLOGY

**Anesthesio
logists**



**Diagnosi
s**

Diagnosis

Diseas e	Disease Type
-------------	-----------------

CORONARY ARTERY DISEASE- UNSTABLE ANGINA
MILD MR,MILD PAH, SR
MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%
CORONARY ANGIOGRAM DONE ON (27/2/2022)
CAD-SVD(LCX)
MEDICAL MANAGEMENT FOR PDA
RISK FACTOR HYPERTENSION,TYPE2 DIABETES MELLITUS

C/o palpitations a/w SOB since 5-6 days

K/C/O T2DM, HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 63 years old male patient Mr. MALLAIAH V came with c/o palpitations a/w SOB since 5-6 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE- UNSTABLE ANGINA MILD MR,MILD PAH, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON (27/2/2022), CAD-SVD(LCX), MEDICAL MANAGEMENT FOR PDA, RISK FACTOR HYPERTENSION,TYPE2 DIABETES MELLITUS. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROSEDAY 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. LOSAR-H 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. GLYCOMET GP2 ONCE DAILY AT 8AM TO CONTINUE.

6. TAB. NIKORAN 5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

54983 narsaiah 66

POSTERIOR CIRCULATION STROKE
CORONARY ANGIOGRAM DONE ON 09/03/2022 - CAD-LEFT MAIN WITH TVD ,
PLAN CABG

C/o giddiness, slurring of speech since 2-3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 66 years old male patient NARSAIAH came with c/o giddiness, slurring of speech since 2-3 days. All necessary investigations were done and diagnosed as POSTERIOR CIRCULATION STROKE. 2D Echo showed inferior wall hypokinesia, Cardiologist consultation taken and advice CAG, S/P CORONARY ANGIOGRAM DONE ON 09/03/2022 - CAD- LEFT MAIN WITH TVD, PLAN CABG. Patient condition and need for further hospital stay explained to patient attendants, but patient attendant requested for discharge, hence discharged at request with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE
- 3) TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE
- 4) TAB. ENCARDIL 5 MG ONCE DAILY AT 8AM TO CONTINUE

REVIEW AFTER 7 DAYS IN DR NIKHIL GOLI OPD

ARH1.000
1228526

Name

Mr
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ARHIP54986

Age

27Y
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Sex

Male

**Date
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07-
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202
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**Date
of
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MLC
No**

**Addr
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RUPNARAYANPET,
ODELA,
PEDDAPALLI,Karimnag
ar,Telangana

**War
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Bed
No**

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Dr Chandra Shekar
Sathineni(

INSECTICIDE POISONING [Fenpropathrin]

ASPIRATION PNEUMONIA

Alleged history of consumption of 400-450 mL of poison (Fenpropathrin) on 07/03/22
at 1.00 A.M.

Initially treated outside hospital and came here for further management

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 27 years old male patient Mr. ARUN GATTU came with alleged history of consumption of 400-450 mL of poison (Fenpropathrin) on 07/03/22 at 1.00 A.M. Initially treated outside hospital and came here for further management. All necessary investigations were done and diagnosed as INSECTICIDE POISONING [FENPROPATHRIN], ASPIRATION PNEUMONIA. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.00012285
22

Name

Mr. N
RAJAMALL
U

**Patient
Identifier**

ARHIP54993

Age

60Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

07-
Mar-
2022

**Date of
Discharge
MLC No**

Address

KORUTAPALLI
RAMADUGU ,Karimn
agar,Telangana

**Ward/
Bed No**

Second
Floor,
Male
General
Ward,
Bed
no:GW
21

**Primary
Consultant**

Dr. Vidya Sagar A

CORONARY ARTERY DISEASE, ANTERIOR WALL MI

MILD LV DYSFUNCTION [EF-50%]

R/F : HYPERTENSION, CVA

CORONARY ANGIOGRAM (09/03/2022) -CAD-TVD [LAD, LCX,RCA]

PLAN -CABG

C/o chest pain with palpitations since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. N RAJAMALLU came with c/o chest pain with palpitations since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MI, MILD LV DYSFUNCTION [EF-50%], R/F : HYPERTENSION, CVA, CORONARY ANGIOGRAM (09/03/2022) -CAD-TVD [LAD, LCX,RCA], PLAN -CABG . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: TELMIKIND-H 80/12.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000122 8514		Name	Mrs. BHAGYALA XMI VELDANDI	
Patient Identifier	ARHIP54978		Age	62Yr 2Mth 9Days
Sex	Female		Date of Admission	06- Mar- 2022
Date of Discharge MLC No				
Address	1-16-291 KMR,Karimnagar,Telangan	Ward/Bed No		First Floor, CICU , Bed no:CIC U4
Primary Consultant	Dr. Vidya Sagar A			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

MILD LV DYSFUNCTION [EF-45%]

R/F : ALCOHOLIC

CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old male patient G. RAJU came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000122 8514		Name	Mrs. BHAGYALA XMI VELDANDI	
Patient Identifier	ARHIP54978		Age	62Yr 2Mth 9Days
Sex	Female		Date of Admission	06- Mar- 2022
Date of Discharge MLC No				
Address	1-16-291 KMR,Karimnagar,Telangan	Ward/Bed No		First Floor, CICU , Bed no:CIC U4
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE , ACUTE IWMI, NO TLT, SR
 SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
 S/P CORONARY ANGIOGRAM DONE ON 08/03/2022 - CAD-DVD
 PLAN CABG.
 R/F DM, HTN, HYPOTHYROIDISM

C/o left sided chest pain since 2 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 62 years old female patient Mrs. BHAGYALAXMI VELDANDI came with c/o left sided chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE IWMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, S/P CORONARY ANGIOGRAM DONE ON 08/03/2022 - CAD-DVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TAZLOC 20MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. THYRONORM 75MCG ONCE DAILY AT 8AM TO CONTINUE.
6. INJ. HUMAN ACTRAPID 14 U AT 8AM, 14 U AT 2PM AND 12 U AT 8PM S/C TO CONTINUE.
7. INJ. HUMAN INSULATARD 14U AT 8AM AND 12 U AT 8PM S/C TO CONTINUE.
8. INJ. LANTUS 10U AT 8PM S/C TO CONTINUE.
9. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS IN CARDIAC OPD

.00012
28582

Name

Mrs.
MANEM
MA
POTHIRE
DDY

**Patient
Identifier**

ARHIP55007

Age

60Yr
0Mth
2Days

Sex

Female

**Date
of
Admission**

08-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

3-41
VADLURBEGUMPET,Karimnaga
r,Telangana

**Ward/
Bed
No**

First
Floor
,
CICU
, Bed
no:CI
CU8

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

ATYPICAL CHEST PAIN, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-55%]

R/F : HYPERTENSION

CORONARY ANGIOGRAM (10/03/2022) -CAD-Mild disease

PLAN MEDICAL MANAGEMENT

C/o sudden retrosternal chest pain a/w sweating

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old female patient Mrs. MANEMMA POTHIREDDY came with c/o sudden retrosternal chest pain a/w sweating . All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-55%], R/F : HYPERTENSION, CORONARY ANGIOGRAM (10/03/2022) -CAD-Mild disease, plan medical management. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TELMA 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001 228444		N a m e	Mrs. KOKKUL A RAJESH WARI	
Patient Identifier	ARHIP54969		Age	73Yr 2Mth 7Day s
Sex	Female		Date of Admis sion	04- Mar- 2022
Date of Discharg e MLC No				
Address	RAPALLE JAGITYAL,GOLLAPALLY,Karimna gar,Telangana		Ward/ Bed No	First Floor, CICU , Bed no:CI CU13
Primary Consulta nt	Dr. Vidya Sagar			

CORONARY ARTERY DISEASE, ANTERIOR WALL MI,
NO THROMBOLIZATION, SR
MILD LV SYSTOLIC DYSFUNCTION, EF-45%
CORONARY ANGIOGRAM DONE ON 21/01/2022 - CAD-SVD (LAD)
PTCA+DES TO LAD WITH 2.5 X 32 MM METAFOR DONE ON 07/03/2022

C/o mild chest pain on and off since 10-12 days

AT ADMISSION:

Afebrile

PR: 88/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 73 years old female patient Mrs. KOKKULA RAJESHWARI came with c/o mild chest pain on and off since 10-12 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MI, NO THROMBOLIZATION, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 21/01/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 2.5 X 32 MM METAFOR DONE ON 07/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. DYTOR 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122
8518

Name

Mr.
MD
ANE
ES

**Patient
Identifier**

ARHIP54984

Age

45Yr
0Mth
4Days

Sex

Male

**Date
of
Admis
sion**

07-
Mar-
2022

**Date of
Discha
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MLC
No**

**Addres
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SIRICILLA,Karimnagar,Tel
angana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U1

**Primar
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Consul
tant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: DENOVO DM, HYPERTENSION

CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-SVD (RAMUS)

PTCA+DES TO RAMUS WITH 2.5 X 13 MM METAFOR DONE ON 07/03/2022
MEDICAL MANAGEMENT FOR DISTAL LAD

C/o Retrosternal chest pain, 1 episode of vomiting

AT ADMISSION:

Afebrile

PR: 96/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 45 years old male patient Mr. MD ANEES came with c/o retrosternal chest pain, 1 episode of vomiting. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: DENOVO DM, HYPERTENSION, CORONARY ANGIOGRAM DONE ON 07/03/2022 - CAD-SVD (RAMUS), PTCA+DES TO RAMUS WITH 2.5 X 13 MM METAFOR DONE ON 07/03/2022, MEDICAL MANAGEMENT FOR DISTAL LAD. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CARDACE 5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 5) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. GLYCOMET SR 500 MG ONCE DAILY AFTER LUNCH TO CONTINUE.
- 7) INJ. HUMAN MIXTARD (30/70) TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001227983

Name

Mrs.
LINGAMPELLY
BAKKAVVA

**Patient
Identifier**

ARHIP54987

Age

46Yr
1Mth
17Days

Sex

Female

**Date of
Admission**

07-Mar-
2022

**Date of
Discharge
MLC No**

Address

4-68/11,
GULLAKOTA JAGTIAL
,Karimnagar,Telanga
na

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU1
0

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

AF WITH FVR (07/03/2022) SEVERE MR, MODERATE PAH, SR
CORONARY ARTERY DISEASE . ACUTE INFERIOR WALL MI, NO TLT .
MODERATE LV SYSTOLIC DYSFUNCTION, EF -40%
CORONARY ANGIOGRAM DONE ON 25.2.2022 CAD - SVD (RCA).
PTCA+DES TO RCA WITH METAFOR 3.5X48MM, DONE ON 25.2.2022

C/o left sided chest pain since 1day .

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-134min

BP-120/80mmhg

RR-34min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-97%

A 46 years old female patient Mrs. LINGAM PALLY BAKKAVVA is presented to hospital with C/o left sided chest pain since 1day All necessary investigations were done and diagnosed as AF WITH FVR (07/03/2022) SEVERE MR, MODERATE PAH, SR, CORONARY ARTERY DISEASE . ACUTE INFERIOR WALL MI, NO TLT, MODERATE LV SYSTOLIC DYSFUNCTION, EF -40%, CORONARY ANGIOGRAM DONE ON 25.2.2022 CAD – SVD (RCA), TCA+DES TO RCA WITH METAFOR 3.5X48MM, DONE ON 25.2.2022. Patient was treated with Antiplatelet, Anticoagulants, Antacids and other supportive measures. Patient is Symptomatically improved. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB.ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB.CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB.CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB.AZTOR 40MG ONCE DAILY AT 9PM TO CONTINUE
- 5) TAB.BETALOC 25MG TWICE AT 8AM AND 8PM TO CONTINUE .
- 6) TAB.CARDARONE 200MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB.RANTAC 150 MG TWICE DAILYAT 8AM(BEFORE BREAK FAST) AND 8PM (BEFORE DINNER) FOR 11 DAYS.

REVIEW AFTER 10DAYS TO CARDIOLOGY OPD WITH FBS/PLBS REPORT.

ARH1.000122782
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Name

Mr. N
RAJESHAM

**Patient
Identifier**

ARHIP54768

Age

75Yr
0Mth
6Days

Sex

Male

**Date of
Admission**

17-Feb-
2022

**Expired Date
MLC No**

23-Feb-2022

Address

RAM
NAGAR,Karimnagar,Telang
ana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 1

**Primary
Consultant**

DR. SRI KARAN UDDESH

PENDING FOR CASE SHEET

ARH1.0001
228138

**N
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Mrs. S
SUVARNA

**Patient
Identifier**

ARHIP54864

Age

58Yr 2Mth
2Days

Sex

Female

**Date of
Admission**

25-Feb-2022

**Expired
Date
MLC No**

26-Feb-2022

Address

10-4-53 BANK
COLONY WARD
50,Karimnagar,T
elangana

**Ward/Bed
No**

First Floor,
SICU, Bed
no:SICU 5

**Primary
Consultan
t**

Dr. Iftekarali (MS
(Orthopaedics),C
onsultant
Orthopaedic
Surgeon)--
ORTHOPAEDICS

**Consultant
s**

Surgeons

Dr. Iftekarali (MS
(Orthopaedics),C
onsultant
Orthopaedic
Surgeon)--
ORTHOPAEDICS

**Anesthesi
ologists**

Dr Subba
Reddy
Kuppannagari
--
ANAESTHESIO
LOGY

Diagnosi
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Diagnosis

Disease	Disease Type
CLOSED COMMUNUTED INTERTROCHANTERIC FRACTURE OF LEFT FEMUR S/P-CEMENTED BIPOLAR HEMIARTHROPLASTY LEFT HIP DONE ON-26/2/2022	

Alleged h/o sustained injury due to slip and fall at home on 24-02-2022

C/o pain and swelling in left hip and shoulder.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-101/min

BP-120/70mmhg

RR-24/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 58 years old female patient Mrs. SUVARNA came with alleged h/o sustained injury due to slip and fall at home on 24-02-2022, c/o pain and swelling in left hip and shoulder. All necessary investigations were done and diagnosed as CLOSED COMMINUTED INTERTROCHANTERIC FRACTURE OF LEFT FEMUR, S/P-CEMENTED BIPOLAR HEMIARTHROPLASTY LEFT HIP DONE ON-26/2/2022. On 26/02/22 at 2.30 pm patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline and atropine given.

ARH1.000122
7826

**Na
me**

Mr. N
RAJESHA
M

**Patient
Identifier**

ARHIP54768

Age

75Yr
0Mth
6Days

Sex

Male

**Date of
Admissi
on**

17-
Feb-
2022

**Expired
Date
MLC No**

23-Feb-2022

Address

RAM
NAGAR,Karimnagar,Tela
ngana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MI
CU 1

**Primary
Consultant**

DR. SRI KARAN UDDESH

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Name

Mr. N
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ARHIP54768

Age

75
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Sex

Male

**Date of
Admissi
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No**

23-Feb-2022

**Add
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RAM
NAGAR,Karimnag
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Bed No**

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**Prim
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DR. SRI KARAN
UDDESH --

**Consulta
nts**

Consultant

INTERNAL
MEDICINE

Surgeon

Dr. SURESH
GOUD S(MS,M.Ch
Urology(SVIMS),
Consultant
Urologist)--
UROLOGY

Anesthesiologist

Diagnosis



Diagnosis

Disease	Disease Type
SEPSIS WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME.	

C/o severe shortness of breath, loss of appetite, generalized weakness, drowsy since 1 day

Known case of diabetes mellitus on treatment

Known case of Hypertension on treatment

AT ADMISSION:

Afebrile

PR: 130/min

BP: 90/60mmHg

RS: BAE+, B/L crackles, B/l wheeze

CVS: S1S2, tachycardia

RR: 37/min

SPO2: 89% with 10 Litrs O2/min

P/A: tenderness to palpation

GCS-12/15

A 75 years old male patient Mr. N RAJESHAM presented with the above-mentioned complaints. Patient was recently admitted for COVID-19, 10 days ago and has been bedridden and cognition has been impaired since then. Now the patient presented with features of diabetic ketoacidosis and AKI. IV fluids and Insulin infusion were given and potassium supplementation was given. Patient was started on DUOLIN and BUDECORT nebulisation and HEPARIN for DVT prophylaxis. Patient had fever spikes patient was started on broad spectrum antibiotics. Patient's clinical status improved and cognition improved over the course of hospitalisation, but he persistently had fever spikes so antibiotics were stepped up to COLISTIN and TEICoplanin and 2D echo was done shows normal. Despite antibiotics patient persisted to have fever spikes and his BP was on the lower side, so patient was started on inotropic support and are suspecting pyelonephritis. The CT KUB was done which showed features suggestive of bilateral pyelonephritis. Urology consultation was taken and patient was planned for DJ stenting. DJ stenting was done, despite DJ stenting patient did not improve. Patient's creatinine was on the rising trend and patient started to have recurrent hypoglycaemia and patient developed ARDS thrombocytopenia and AKI was sent. A nephrology opinion was taken in view of severe metabolic acidosis and dialysis was planned, but at to 2.10 p.m. on 23/02/2022. Patient developed bradycardia. CPR initiated according to ACLS guidelines but despite best efforts patient could not be revived and hence declared dead at 2:18 p.m. on 23 /02/ 2022.

CAUSE OF DEATH

SEPSIS WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME.

54865 kiran 38

A 38 years old male patient Mr. E KIRAN presented to hospital with c/o chest heaviness, SOB on exertion, chest pain, intercapsular radiating to back associated with palpitations since 6-7 days. Symptoms aggravated since 23/02/2022. H/o fever with chills, cold and cough with eye burning since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, EVOLVED ANTERIOR WALL MI, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-20%. LV BLOOD CLOTS. VT 2 EPISODES /DC SHOCK SR. Intermittent NIV support was given in view of desaturation. Poor prognosis explained to the patient attendants, suddenly patient, developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. Patient reverted to NSR. CPR was continued, patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 3.40 PM on 01/03/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO CORONARY ARTERY DISEASE, EVOLVED
 ANTERIOR WALL MI,
 MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-20%, LV BLOOD CLOTS, VT 2
 EPISODES /DC SHOCK SR.

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Name

Mr.
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ARHIP54817

Age

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Sex

Male

**Date of
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27-Feb-2022

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Dr. Vidya Sagar
 A--CARDIOLOGY

**Consulta
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Dr. Vidya Sagar
 A--CARDIOLOGY

**Anesthe
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**Diagnosi
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Diagnosis

CAD-AWMI,CHB,SEVERE LV SYSTOLIC DYSFUNCTION. EF: 35%

C/o chest pain since 2 days, pain radiating to back

AT ADMISSION:

Afebrile

PR: 109/min

BP: 120/90mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 99%

P/A: Soft,

A 63 years old male patient Mr. GUMMULA NARSAIAH presented to hospital with c/o chest pain since 2 days, pain radiating to back. **All necessary investigations were done and diagnosed as** CAD-AWMI, CHB, SEVERE LV SYSTOLIC DYSFUNCTION. EF: 35%. **Poor prognosis explained to the patient attendants**. Patient suddenly became unconscious heart rate was < 60 /bpm, BP not recordable and inotrope support was given, immediately emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2 100%, INJ. NORAD 20 ml/hr given. CPR continued for 4-5 minutes according to ACLS guidelines, INJ. ATROPINE and INJ. ADRENALINE were given. Peripheral pulses were not felt, 12 lead ECG showed flat line. Hence death declared at 12.07 PM on 27-02-2022.

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8626

**Na
me**

Mrs.
BITLA
RAJAVV
A

**Patient
Identifier**

ARHIP55008

Age

77Yr
0Mth
3Days

Sex

Female

**Date
of
Admiss
ion**

08-
Mar-
2022

**Date of
Discharge
MLC No**

Address

SANIGARAM,SIDDIPET,Tela
ngana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U2

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE , NSTEMI,

MILD MR, MILD LV SYSTOLIC DYSFUNCTION

CORONARY ANGIOGRAM DONE ON 10/03/2022 - CAD-TVD [LAD, LCX, RCA]

ADV: CABG WTH GRAFT TOT LAD, OM, DISTAL RCA

C/o sudden onset of chest pain a/w chest heaviness

At Admission

Afebrile

PR: 65/min

BP: 120/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 77 years old female patient Mrs. BITLA RAJAVVA came with c/o sudden onset of chest pain a/w chest heaviness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, MILD MR, MILD LV SYSTOLIC DYSFUNCTION, CORONARY ANGIOGRAM DONE ON 10/03/2022 - CAD-TVD [LAD, LCX, RCA], ADV: CABG WTH GRAFT TOT LAD, OM, DISTAL RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM BEFORE FOOD FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

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Name

Mr.
TOG
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KAL
ACH
ARI

**Pati
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ARHIP54966

Age

61
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Sex

Male

**Dat
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2-71
KANDLAPALLY,KARIMNAGAR,
Karimnagar,Telangana

**Wa
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Bed
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Be
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CI
CU
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Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

MILD LV SYSTOLIC DYSFUNCTION [EF-50 %]

CORONARY ANGIOGRAM (08/03/2022) -CAD-SVD (RCA)

PTCA+DES TO RCA (TWO STENTS) WITH 3.0 X 37 MM METAFOR, 3.5 X 16 MM
METAFOR DONE ON 08/03/2022

R/F : HYPERTENSION

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 61 years old male patient Mr. TOGITI KALACHARI came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50 %], CORONARY ANGIOGRAM (08/03/2022) -CAD-SVD (RCA), PTCA+DES TO RCA (TWO STENTS) WITH 3.0 X 37 MM METAFOR, 3.5 X 16 MM METAFOR DONE ON 08/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETALOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

- 6) TAB. CILACAR 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. MINIPRESS-XL 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55000

ARH1.0001 228551		Name	Mrs. PITLA MALLA VVA
Patient Identifier	ARHIP55000	Age	51Yr 0Mth 5Days
Sex	Female	Date of Admission	07- Mar- 2022
Date of Discharge MLC No			
Address	NARAYANARAO PET, Karimnagar, Telangana	Ward/Bed No	First Floor, CICU , Bed no: CIC U12
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, AWMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION [EF-60 %]

CORONARY ANGIOGRAM (09/03/2022) -CAD-DVD (LAD, RCA)

PTCA+DES TO LAD,RCA (TWO STENTS) LAD WITH 2.75 X 12 MM 3V ASTRA, RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 09/03/2022
R/F : HYPERTENSION

C/o left sided chest pain since 7 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 51 years old female patient Mrs. PITLA MALLAVVA came with c/o left sided chest pain since 7 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60 %], CORONARY ANGIOGRAM (09/03/2022) -CAD-DVD (LAD, RCA), PTCA+DES TO LAD,RCA (TWO STENTS) LAD WITH 2.75 X 12 MM 3V ASTRA, RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 09/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00
0122862
8

Name

Mrs.
PAT
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ARHIP55025

Age

43Y
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Sex

Female

**Dat
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10-
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MLC
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H.NO:111-
8/1,JULAPALLY,PEDDAP
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**War
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Bed
No**

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CIC
U11

**Pri
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Dr. Vidya Sagar A

ATYPICAL CHEST PAIN, ANAEMIA
NORMAL LV SYSTOLIC FUNCTION
CORONARY ANGIOGRAM (11/03/2022) - NORMAL CORONARIES
PLAN MEDICAL MANAGEMENT

BLOOD TRANSFUSION DONE ON 09/03/2022

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old female patient Mrs. PATAKULA LAXMI came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, ANAEMIA, NORMAL LV SYSTOLIC FUNCTION, CORONARY ANGIOGRAM (11/03/2022) - NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT, BLOOD TRANSFUSION DONE ON 09/03/2022. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. LIVOGEN ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. FOLVITE 5 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
4. INJ. OPTINEURON 1 AMP IM ONCE IN A WEEK

REVIEW AFTER 11 DAYS TO CARDIAC OPD

LABYRINTHITIS

CORONARY ARTERY DISEASE,

UNSTABLE ANGINA WITH ECG CHANGES, LBBB, SEVERE MR

MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%]

C/o giddiness a/w vomiting 3-4 episodes

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 70/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 72 years old female patient **Mrs. PRAMELA KOLANI** came with c/o giddiness a/w vomiting 3-4 episodes. All necessary investigations were done and diagnosed as LABYRINTHITIS, CORONARY ARTERY DISEASE, UNSTABLE ANGINA WITH ECG CHANGES, LBBB, SEVERE MR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-35%]. Advised angiogram, they are refused further treatment and angiogram. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AZTOR 10MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. CTD 6.25 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB: ALDACTONE 25 MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB: SPINFREE THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS
6. TAB: VERTIN 8 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB: PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.000122
8667

**Na
me**

Mrs. NUSRATH .

**Patient
Identifier**

ARHIP55019

Age

50Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

09-
Mar-

Date of Discharge

11-Mar-2022

MLC No**Address**PEDDAPALLI,HANUMAN
NAGAR,Karimnagar,Tel
angana**Ward/Bed
No**First
Floor,
HDU,
Bed
no:HD
U12**Primary
Consultant**DR. SRI KARAN
UDDESH --INTERNAL
MEDICINE**Consultants****Surgeons****Anesthesiolo
gists**Diagnosi
s**Diagnosis**[Add Diagnosis](#)

Disease	Disease Type
.	Pd

SEPTIC SHOCK (RESOLVED)
MICROCYTIC ANEMIA
K/C/O HYPERTENTION

C/o High grade fever with chills since 10-15 days

History of burning micturition since 10 days

History of generalised weakness

History of palpitation since 1 day

Known case of hypertension on irregular medication

AT ADMISSION:

Patient conscious

PR: 100/min

BP: 80/60mmHg with Noradrenaline support
RS: BAE+

CVS: S1S2

RR: 21/min

SPO2: 96%

P/A: Soft

A 50 years old female patient Mrs. NUSRATH presented to ER with above-mentioned complaints. On examination patient conscious and diagnosed as SEPTIC SHOCK. Patient was started with INJ. MEROFIT PLUS EDTA, INJ. DOXY, IV fluids, NORADRENALINE over the next 24 hours, BP improves ionotrope support tapered and stopped. Sr. Procalcitonin was sent to which was 16.2 mg/dl . Blood culture, urine culture were ordered both reports are pending. Patient attendants were explained about need further antibiotic support and hospitalisation. Due to offerdebility issues patient attendant are willing for discharge. Hence patient is being discharged against medical advice.

ARH1.000112
4996

**Na
me**

Mr. V
RAJAIAH

**Patient
Identifier**

ARHIP54974

Age

64Yr
0Mth
21Da
ys

Sex

Male

**Date
of
Admiss
ion**

05-
Mar-
2022

**Date of
Discharge
MLC No**

Address

ULLAMPALLI,Karimnagar,Te
langana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MI
CU 7

**Primary
Consultant**

Dr Chandra Shekar
Sathineni(MD)

DIABETIC KETOACIDOSIS
LOWER RESPIRATORY TRACT INFECTION

C/o giddiness, headache and generalized weakness

H/o fever, chest pain a/w SOB

AT ADMISSION:

Afebrile

PR: 98/min

BP: 160/100mmHg

RS: BAE+

CVS: S1S2

RR: 22/min

SPO2: 100%

P/A: Soft

A 64 years old male patient Mr. V RAJIAH came with c/o giddiness, headache and generalized weakness, h/o fever, chest pain a/w SOB. All necessary investigations were done and diagnosed as DIABETIC KETOACIDOSIS, LOWER RESPIRATORY TRACT INFECTION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. NICARDIA RETARD 20 MG ONCE DAILY AT 8AM TO CONTINUE
- 4) INJ. LANTUS 30 Units ONCE DAILY AT 8PM FOR 10 DAYS
- 5) TAB. DAPEFY 10 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 6) TAB. ARVAST 20 MG ONCE DAILY AT 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001228
767

Name

Mr. N
RAM
REDDY

Patient Identifier

ARHIP55043

Age

60Yr
0Mth
3Days

Sex

Male

Date of Admission

11-
Mar-
2022

**Date of Discharge
MLC No**

Addresses

GOLLAPALLI
JAGITTIAL, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CIC
U2

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, AWMI, SR, NO TLT

MILD LV SYSTOLIC DYSFUNCTION [EF-55%]

R/F : SMOKING, ALCOHOL

CORONARY ANGIOGRAM (12/03/2022) -CAD-SVD (LAD)

THROMBUS ASPIRATION DONE ON 12/03/2022, TIMI-III FLOW ACHIEVED

ADV: MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. N RAM REDDY came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, NO TLT, MILD LV SYSTOLIC DYSFUNCTION [EF-55%], R/F : SMOKING, ALCOHOL, CORONARY ANGIOGRAM (12/03/2022) -CAD-SVD (LAD), THROMBUS ASPIRATION DONE ON 12/03/2022, TIMI-III FLOW ACHIEVED, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AX CER 90 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
3. TAB. ROZUVAS 40MG ONCE DAILY AT 9PM TO CONTINUE.
4. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012042
58

Name

Mr.
MOHAMMA
D ZAFAR
AHMED

**Patient
Identifier**

ARHIP55009

Age

37Yr
7Mth
0Days

Sex

Male

**Date of
Admission**

08-Mar-
2022

**Date of
Discharge
MLC No**

Address

1-348,Shimla
Nagar,KOMARA
M
BHEEM,Sirpur
(T),Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

**Primary
Consultant**

Dr. Vidya Sagar
A--
CARDIOLOGY

CORONARY ARTERY DISEASE, IWMI, SR,

MILD LV SYSTOLIC DYSFUNCTION [EF-50 %]

CORONARY ANGIOGRAM (08/03/2022) -CAD-SVD (RCA)

PTCA+DES TO RCA (TWO STENTS) WITH 3.0 X 37 MM METAFOR, 3.5 X 16 MM
METAFOR DONE ON 08/03/2022

R/F : HYPERTENSION

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 61 years old male patient Mr. TOGITI KALACHARI came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION [EF-50 %], CORONARY ANGIOGRAM (08/03/2022) -CAD-SVD (RCA), PTCA+DES TO RCA (TWO STENTS) WITH 3.0 X 37 MM METAFOR, 3.5 X 16 MM METAFOR DONE ON 08/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETALOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. CILACAR 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. MINIPRESS-XL 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012287
08

Name

Mr. NALMACHU
CHANDRAMOULI

Patient Identifier

ARHIP55029

Age

56Yr
2Mth
4Days

Sex

Male

Date of Admission

10-
Mar-
2022

Date of Discharge
MLC No

Address

2-
36/1, RAMADUGU, Karimnagar, Telangana

Ward/Bed No

Second
Floor,
Male
General Ward,
Bed no: GW
15

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI

MILD LV DYSFUNCTION [EF-50%]

CORONARY ANGIOGRAM (14/03/2022) -CAD-Proximal LAD Recanalized

PLAN MEDICAL MANAGEMENT

C/o chest pain since 3 months

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 74/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old male patient Mr. NALMACHU CHANDRAMOULI came with c/o chest pain since 3 months. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MILD LV DYSFUNCTION [EF-50%], CORONARY ANGIOGRAM (14/03/2022) -CAD-Proximal LAD Recanalized, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. LOSAR 50MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012042
58

Name

Mr.
MOHAMMA
D ZAFAR
AHMED

**Patient
Identifier**

ARHIP55009

Age

37 Yr
7Mth
0Days

Sex

Male

**Date of
Admission**

08-Mar-
2022

**Date of
Discharge**

MLC No

Address

1-348,Shimla
Nagar,
KOMARAM
BHEEM,
Sirpur
(T),Telangan
a

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

**Primary
Consultant**

Dr. Vidya
Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, AWTMI, SR, NO TLT

S/P CORONARY ANGIOGRAM DONE ON 02/02/2021

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 11/03/2022 - CAD-SVD (LAD)

PTCA+DES TO LCX WITH 2.75 X 32 MM 3V ASTRA, RCA WITH 2.5 X 32 MM METAFOR
DONE ON 11/03/2022

R/F: T2DM

C/o left sided chest pain a/w SOB since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 37years old male patient Mr. MOHAMMAD ZAFAR AHMED came with c/o left sided chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SR, NO TLT, S/P CORONARY ANGIOGRAM DONE ON 02/02/2021, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 11/03/2022 - CAD-SVD (LAD), PTCA+DES TO LCX WITH 2.75 X 32 MM 3V ASTRA, RCA WITH 2.5 X 32 MM METAFOR DONE ON 11/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. COLODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. GLYCOMET GP1 ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. THYRONORM 125 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55055 AGAVVA

DRUG OVERDOSE (NEXITO PLUS) POISONING
CERVICAL SPONDYLOSIS
KNOWN CASE OF DEEP VEIN THROMBOSIS
TYPE II DIABETIC MELLITUS, HYPERTENSION

Alleged h/o consumption of TAB. NEXITO PLUS around 9 Tablets at 8 p.m. on
12/03/2022

AT ADMISSION:

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

61-year-old female patient Mrs AGAVVA presented with above-mentioned complaints. All necessary investigations done and diagnosed as DRUG OVERDOSE (NEXITO PLUS) POISONING, CERVICAL SPONDYLOSIS, KNOWN CASE OF DEEP VEIN THROMBOSIS, TYPE II DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Patient attendant requested for discharge. Hence patient is being discharged on request.

DISCHARGE MEDICATION:

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. ARIGABA 600 MG ONCE DAILY AT 8PM TO CONTINUE
- 3) TAB. TOLMOVE 450 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. RAZO-L ONCE DAILY AT 8AM BBF FOR 5 DAYS
- 5) TAB. DAPARYL 10 MG ONCE DAILY AT 8AM BBF FOR 5 DAYS
- 6) TAB. IXAROLA 5 MG ONCE DAILY AT 8AM BBF FOR 5 DAYS
- 7) TAB. LIVOGEN ONCE DAILY AT 2PM FOR 5 DAYS
- 8) SILVEREX OINTMENT FOR L/A TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001228838		Name	Mr. SANTHOSH MUKKA	
Patient Identifier	ARHIP55056	Age	33Yr 0Mth 2Days	
Sex	Male	Date of Admission	13-Mar-2022	
Date of Discharge				
MLC No				
Address	KMR,Karimnagar,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU 8	
Primary Consultant Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	Consultants		

S

DCMP, VPC, MODERATE MR, SR
 SEVERE LV SYSTOLIC DYSFUNCTION, [EF-20%]
 ACUTE KIDNEY INJURY (Sr. Creatinine 1.6 mg/dl)
 SYNCOPE FOR EVALUATION (DRUG INDUCED)
 STOPPED TAB. VYMADA (**SACUBITRIL AND VALSARTAN**)

C/o chest pain associated with shortness of breath shortness of breath since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 100/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft

A 33 years old male patient Mr. SANTHOSH MUKKA came with c/o **chest pain associated with shortness of breath shortness of breath since 1 day**. All necessary investigations were done and diagnosed as DCMP, VPC, MODERATE MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, [EF-20%], ACUTE KIDNEY INJURY (Sr. Creatinine 1.6 mg/dl), SYNCOPE FOR EVALUATION (DRUG INDUCED), STOPPED TAB. VYMADA (**SACUBITRIL AND VALSARTAN**), Nephrologist consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CONCOR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. PLANEP-T 10 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. ROSUFIT-CV 10 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. FEBUGET 40 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. LANOXIN 0.25 MG ALTERNATE DAY AT 8AM TO CONTINUE.
6. TAB. NEXPRO 40 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. NEUROKIND-LC ONCE DAILY AT 2PM TO CONTINUE.
8. TAB. POLYBION CZS ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001228 718		Name	Mr. RAMULU KANKANAL A	
Patient Identifier	ARHIP55034		Age	66Yr 0Mth 5Days
Sex	Male		Date of Admission	11-Mar-2022
Date of Discharge MLC No				
Address	1-84/1 BADDIAPALLY,Karimnagar,Telangan		Ward/ Bed No	First Floor, CICU , Bed no:CICU10
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE AWMI (DAY 4)

MODERATE MR, SEVERE PAH

SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

LV APICAL ANEURYSM

CORONARY ANGIOGRAM DONE ON 12/03/2022 - CAD-DVD (LAD & RCA)

PTCA+DES TO LAD WITH 3.0 X 44 MM METAFOR DONE ON 12/03/2022

C/o chest pain since 4 days

AT ADMISSION:

Afebrile

PR: 103/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 66 years old male patient Mr. RAMULU KANKANALA came with c/o chest pain since 4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI (DAY 4), MODERATE MR, SEVERE PAH, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, LV APICAL ANEURYSM, CORONARY ANGIOGRAM DONE ON 12/03/2022 - CAD-DVD (LAD & RCA), PTCA+DES TO LAD WITH 3.0 X 44 MM METAFOR DONE ON 12/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

-
- 1) TAB. DISPRIN 325MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE WITH 100 ml WATER.
 - 2) TAB. CLOPITAB 75MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
 - 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
 - 4) TAB. GOUTNIL 0.5 MG ONCE DAILY AT 8AM TO CONTINUE.
 - 5) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 10 AM TO CONTINUE.
 - 6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001 228323		N a m e	Mrs. RAJESHWAR AVVA BODAKUNTI	
Patient Identifier	ARHIP54915		Age	70Y r 0Mt h 15D ays
Sex	Female		Date of Admission	28- Feb- 202 2
Date of Discharge MLC No				
Address	H.NO:3- 46,POTYALA,ATHARGAM,PEDDAPALLY,Ot her,Telangana		Ward/Bed No	First Floo r, SIC U, Bed no:S ICU 6
Primary Consultan t	DR. SUBRAT KUMAR SOREN			

ACUTE RUPTURE OF ACOM ANEURYSM +DIFFUSE SAH + INTRACEREBRAL BLEED

SURGERY: RIGHT FRONTO-TEMPORO-PARIETAL CRANIOTOMY AND MICROSURGICAL CLIPPING OF ACOM ANEURYSM DONE ON 02/03/2022

C/o sudden collapse at home at around 5 p.m. on 27/02/2022 followed by altered sensorium, 1 episode of vomiting+

AT ADMISSION:

Patient is conscious, obey commands, irritable

PR: 86/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96% on room air

P/A: Soft

GCS -12/15

A 70 years old female patient Mrs. RAJESHWARAVVA BODAKUNTI came with c/o sudden collapse at home at around 5 p.m. on 27/02/2022 followed by altered sensorium, 1 episode of vomiting+. All necessary investigations were done and diagnosed as ACUTE RUPTURE OF ACOM ANEURYSM +DIFFUSE SAH + INTRACEREBRAL BLEED, SURGERY: RIGHT FRONTO-TEMPORO-PARIETAL CRANIOTOMY AND MICROSURGICAL CLIPPING OF ACOM ANEURYSM DONE ON 02/03/2022. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ROXSAFE CV TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
2. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM TILL CONTINUE
3. TAB. LASOSAMIDE 50 MG ONCE DAILY AT 8AM TILL CONTINUE
4. TAB. TOLVAPTAN 15 MG ONCE DAILY AT 2PM FOR 7 DAYS
5. TAB. NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS
6. TAB. NIMODIPINE 30 MG 4th hrly FOR 7 DAYS
7. TAB. DOLO 650 MG SOS
8. SYP. DUPHALAC SOS

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

55080

ARH1.00012288 46		Name	Mr. SRINIVAS V
Patient Identifier	ARHIP55080	Age	52Yr 0Mth 3Days
Sex	Male	Date of Admission	15- Mar- 2022
Date of Discharge MLC No			
Address	GANESH NAGAR,,Karimnagar,Telangana	Ward/ Bed No	Second Floor, Semi Private , Bed no:122 A
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

ANAEMIA

ONE PACKED CELL TRANSFUSION DONE ON 15/03/2022

ATYPICAL CHEST PAIN

CORONARY ARTERY DISEASE,

NON-ST ELEVATED MYOCARDIAL INFARCTION
R/F : T2DM, HTN

CORONARY ANGIOGRAM (16/03/2022) -NORMAL CORONARIES
PLAN MEDICAL MANAGEMENT

C/o chest pain a/w mild sweating since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. SRINIVAS came with c/o chest pain a/w mild sweating since 2 days . All necessary investigations were done and diagnosed as ANAEMIA, ONE PACKED CELL TRANSFUSION DONE ON 15/03/2022, ATYPICAL CHEST PAIN, CORONARY ARTERY DISEASE, R/F : T2DM, HTN, CORONARY ANGIOGRAM (16/03/2022) -NORMAL CORONARIES , PLAN MEDICAL MANAGEMENT. General Physician consultation taken advised UGI Endoscopy, colonoscopy but patient attendants are not willing. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ATORVA 20 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. HOMIN-D3 TWICE DAILY AT 8AM 8PM TO CONTINUE.
3. TAB. SARTEL-LN 40/10 TWICE DAILY AT 8AM 8PM TO CONTINUE.
4. TAB: ZAPIZ ONCE DAILY AT 8PM TO CONTINUE.
5. TAB: REXIPRA 15 MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB: QUETIAPINE 200 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012288
64

Name

Mr. K
RAJAIAH

**Patient
Identifier**

ARHIP55088

Age

56Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

15-
Mar-
2022

**Date of
Discharge
MLC No**

Address

LINGAPUR,
MANAKONDUR,Karimnagar,Telan
gana

**Ward/
Bed No**

Secon
d
Floor,
Semi
Privat
e, Bed
no:10
3 A

**Primary
Consultant**

Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General
Surgeon)--GENERAL SURGERY

LEFT PRIMARY HYDROCELE
SURGERY: LEFT HYDROCELECTOMY DONE ON 16/03/2022

C/o Left scrotal swelling since few days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 56yr old male patient Mr. RAJIAH came with c/o left scrotal swelling since few days. All necessary investigations done and diagnosed as LEFT PRIMARY HYDROCELE, SURGERY: LEFT HYDROCELECTOMY DONE ON 16/03/2022. Findings: Moderately fluid filled sac, Testis and epidermoid appear normal. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ROTAVALT THRICE DAILY AT 8AM, 2PM AND 8PM FOR 7 DAYS.
3. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
5. TAB: FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 15 DAYS.
6. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

DRAIN CARE

SCROTAL SUPPORT

Review after 10 days in General Surgery OPD.

ARH1.0001228 924		Na me	Mr. AJAY CHINTALA	
Patient Identifier	ARHIP55090		Age	27Yr 0Mth 2Days
Sex	Male		Date of Admission	15- Mar- 2022
Date of Discharge MLC No				
Address	H.NO:6- 72,KONDAPUR,KARIMNAGAR,Telan gana	Ward/ Bed No		Secon d Floor, Semi Privat e, Bed no:10 8 B
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY			
ACUTE APPENDICITIS SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 16.03.2022				

C/o pain abdomen since 2 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 27yr old male patient Mr. AJAY CHINTALA came with c/o pain abdomen since 2 days. All necessary investigations done and diagnosed as ACUTE APPENDICITIS, SURGERY: LAPROSCOPIC APPENDICECTOMY DONE ON 16.03.2022. Findings: Appendix inflamed and noted in pelvis position. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
4. TAB: FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 15 DAYS.
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.00012
28766

Name

Mr.
SRINIV
AS
THUMM
ALA

**Patient
Identifier**

ARHIP55044

Age

39Yr
0Mth
6Days

Sex

Male

**Date
of
Admission**

12-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

1-15, DESHAIPALLY
RAJANNA,Sircilla,Tel
angana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, IWMI, SR, NO TLT

NORMAL LV FUNCTION, EF-58%

R/F: ALCOHOL, TOBACCO

CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR DONE ON 14/03/2022

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 39 years old male patient Mr. SRINIVAS THUMMALA came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, SR, NO TLT, NORMAL LV FUNCTION, EF-58%, R/F: ALCOHOLIC, TOBACCO, CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 13 MM METAFOR DONE ON 14/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM 8PM TO CONTINUE
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000
1096446

Name

Mr.
RAJ
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**Pati
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ARHIP55020

Age

71
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Sex

Male

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Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE -ACUTE IWMI(OUT OF WP),NO TLT,SR,KILLIP2,MODERATE LV DYSFUNCTION(EF-37%),R/F-T2DM,HTN,CAG(30/12/15)-DVD(LAD,RCA),PRIMARY PTCA+DES(BIOMINE-3.5X24MM)TO RCA DONE ON(30/12/15),MEDICAL MANAGEMENT FOR LAD DIAGONAL,

R/F : T2DM

PP: CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-SVD (LAD)

MEDICAL MANAGEMENT FOR PROXIMAL RCA ISR

PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR DONE ON 14/03/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 71years old male patient Mr. RAJIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE -ACUTE IWMI(OUT OF WP),NO TLT,SR,KILLIP2,MODERATE LV DYSFUNCTION(EF-37%),R/F-T2DM,HTN,CAG(30/12/15)-DVD(LAD,RCA),PRIMARY PTCA+DES(BIOMINE-3.5X24MM)TO RCA DONE ON(30/12/15),MEDICAL MANAGEMENT FOR LAD DIAGONAL, R/F : T2DM, PP: CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-SVD (LAD), MEDICAL MANAGEMENT FOR PROXIMAL RCA ISR, PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR DONE ON 14/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CARDIVAS 3.125 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. RAMISTAR 5 MG ONCE DAILY AT 2PM TO CONTINUE.

6) TAB. GLYCOMET SR 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

7) TAB. GEMER 1 ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
228845

Name

Mr.
NARAY
ANA
GEEKU
RU

**Patie
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Identi
fier**

ARHIP55059

Age

57Yr
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Sex

Male

**Date
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Admi
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**Date
of
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**Addre
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2-55
KAMANPUR, Karimnagar,
Telangana

**Ward/
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**Prima
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Consu
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Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI [13/03/2022], NO TLT, SR

MILD LV DYSFUNCTION, EF-50%

R/F: HTN, T2DM DENOVO (17/03/2022)

CVA LEFT HEMIPLEGIA (18 Yrs)

CORONARY ANGIOGRAM DONE ON 13/03/2022 - CAD-TVD (LAD, LCX, RCA)

PRIMARY PTCA+2DES [METAFOR 3.0 X 16 MM TO MID RCA + METAFOR 2.75 X 16 MM
TO DISTAL RCA]
DONE ON 13/03/2022

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 57 years old male patient Mr. NARAYANA GEEKURU came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI [13/03/2022], NO TLT, SR, MILD LV DYSFUNCTION, EF-50%, R/F: HTN, T2DM DENOVO (17/03/2022), CVA LEFT HEMIPLEGIA (18 Yrs), CORONARY ANGIOGRAM DONE ON 13/03/2022 - CAD-TVD (LAD, LCX, RCA), PRIMARY PTCA+2DES [METAFOR 3.0 X 16 MM TO MID RCA + METAFOR 2.75 X 16 MM TO DISTAL RCA] DONE ON 13/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RAMISTAR 5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ZORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001228 769		Name	Mr. RAJESHVA R RAO PUNUGOTI	
Patient Identifier	ARHIP55047		Age	71Yr 0Mth 5Days
Sex	Male		Date of Admission	12- Mar- 2022
Date of Discharge MLC No				
Address	H.NO:2- 44,HASNABAD,JAGITIAL,Other,Tel angana	Ward/ Bed No		First Floor, MICU, Bed no:MIC U 12
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ANGINA

CORONARY ANGIOGRAM -2VD; (TANDUM RCA+LCA BORDER LINE)

GOOD LV FUNCTION, EF-48%

R/F: HTN, T2DM

CORONARY ANGIOGRAM DONE ON 12/03/2022 - CAD-SVD (RCA)

PTCA+DES TO LAD WITH 3.0 X 40 MM 3V ASTRA DONE ON 15/03/2022

C/o chest pain on and off since 15 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 71 years old male patient Mr. RAJESHVAR RAO PUNUGOTI came with c/o chest pain on and off since 15 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANGINA, CORONARY ANGIOGRAM -2VD; (TANDUM RCA+LCA BORDER LINE), GOOD LV FUNCTION, EF-48%, R/F: HTN, T2DM, CORONARY ANGIOGRAM DONE ON 12/03/2022 - CAD-SVD (RCA), PTCA+DES TO LAD WITH 3.0 X 40 MM 3V ASTRA DONE ON 15/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. DAPEFY 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ALDACTONE 25 MG ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
28979

Name

Mrs.
VALA
SUMA
HILA

**Patient
Identifier**

ARHIP55103

Age

74
Yr
0M
th
0D
ay
s
17
-
Mar-
20
22

Sex

Female

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

MUKARAMPURA,Kataram,
Telangana

**Ward/
Bed
No**

Fir
st
Floor,
Day
Care,
Bed
no:
DC
2

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

ATYPICAL CHEST PAIN
SR, NORMAL LV SYSTOLIC FUNCTION
R/F : HTN

CORONARY ANGIOGRAM (17/03/2022) - NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o Burning sensation in chest sudden onset

K/c/o HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 74 years old female patient Mrs. VALA SUMAHILA came with c/o burning sensation in chest sudden onset. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION, R/F : HTN, CORONARY ANGIOGRAM (17/03/2022) - NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. STORVAS 10 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STARPRESS R XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. PANTOCID DSR ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.000122855
0

Name

Mr.
POCHALU
P

Patient Identifier

ARHIP55042

Age

60Yr
0Mth
10Days

Sex

Male

Date of Admission

11-Mar-2022

**Date of Discharge
MLC No**

Address

KANAGARTHI,
PEDDAPALLI, ,Karim
nagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
7

Primary Consultant

Dr. Vidya Sagar A

UNSTABLE ANGINA, SEVERE MR, MODERATE PAH, SR
MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%
R/F: HTN, EX. SMOKER
CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-DVD (LCX, RCA)

PTCA+2DES TO RCA [METAFOR 3.5 X 37 MM TO MID RCA + METAFOR 2.75 X 40 MM
TO DISTAL RCA]
DONE ON 14/03/2022
MEDICAL MANAGEMENT FOR LCX

C/o chest pain since 5 days associated with shortness of breath and palpitations

AT ADMISSION:

Afebrile

PR: 79/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 60years old male patient Mr. POCHALU came with c/o chest pain since 5 days associated with shortness of breath and palpitations. All necessary investigations were done and diagnosed as UNSTABLE ANGINA, SEVERE MR, MODERATE PAH, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, R/F: HTN, EX. SMOKER
CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-DVD (LCX, RCA), PTCA+2DES TO RCA [METAFOR 3.5 X 37 MM TO MID RCA + METAFOR 2.75 X 40 MM TO DISTAL RCA] DONE ON 14/03/2022, MEDICAL MANAGEMENT FOR LCX. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122
8873

Name

Mr.
KADAS
U
SRINIV
AS

**Patient
Identifier**

ARHIP55069

Age

43Yr
0Mth
3Days

Sex

Male

**Date
of
Admis
sion**

14-Mar-
2022

**Date
of
Discha
rge
MLC
No**

**Addres
s**

RUDRANGI,RAJA
NNA
SIRCILLA,Telang
ana

**Ward/
Bed
No**

First
Floor,
RECOVER
ROOM,
Bed
no:RR 7

**Primar
y
Consul
tant**

Dr. SURESH
GOUD S(MS

RIGHT RENAL CALCULUS

C/o Pain in right loin region since 1 week

ON ADMISSION

Pt c/c

Afebrile

PR-80/min

BP-110/70mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

A 43 yr old male patient Mr. KADASU SRINIVAS came with c/o Pain in right loin region since 1 week. All necessary investigations were done and diagnosed as RIGHT RENAL CALCULUS, RIGHT PERCUTANEOUS NEPHROLITHOTRIPSY procedure cancelled due to abnormal calyceal anatomy. Patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
3. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
4. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS

Review after 11 days to urologist OPD.

ARH1.000 1228512	Name		Mr. SRIP ATHI LAXM AIAH		
	Patient Identifier	ARHIP54976		Age	84Y r 0Mt h 1D ays 06- Mar - 202 2
	Sex	Male		Date of Admission	
	Expired Date	06-Mar-2022			

Primary Consultant Surgeons

KARIMNAGAR,Karimnagar,Telangana

Dr. Vidya Sagar A--
CARDIOLOGY

Ward/Bed
No

Consultants

Anesthesiologists

First Floor, MIC U, Bed no: MIC U 12

Diagnosi

Diagnosis

Disease	Disease Type
•	

SEPSIS,METABOLIC ACIDOSIS,HYPERKALEMIA

C/o chest pain since 3 days

AT ADMISSION:

PR: 84/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 84 years old male patient Mr. SRIPATHI LAXMAIAH came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as SEPSIS, METABOLIC ACIDOSIS, HYPERKALEMIA. Poor prognosis explained to the patient attendants, suddenly patient developed bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and

ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 08.01 PM on 06/03/2022.

CAUSE OF DEATH

SEPSIS,METABOLIC ACIDOSIS,HYPERKALEMIA

ARH1.00012
28779

Name

Mr. K
PRABHA
KAR

**Patient
Identifier**

ARHIP55048

Age

26Yr
0Mth
6Days

Sex

Male

**Date
of
Admission**

12-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

BHAGATH
NAGAR,Karimnagar,T
elangana

**Ward/
Bed
No**

First
Floor,
CICU
, Bed
no:CI
CU4

**Primary
Consultant
Surgeons**

Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

DCMP, SEVERE MR, MILD PAH, SR,

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

SVT (14/03/2022) VAGAL SR

CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old male patient G. RAJU came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001228266	ARHIP55016	Mr. RAMESH SAMUDRALA Male 38Yr 0Mth
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RIGHT PROXIMAL URETERIC CALCULUS
RIGHT PUSH BACK PCNL+DJ STENTING DONE ON 14.02.2022

C/o Right loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 38 yrs old male patient RAMESH came to the hospital with c/o right loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, RIGHT PUSH BACK PCNL+DJ STENTING DONE ON 14.02.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

Review after 11 days, stent removal after 3 weeks

ARH1.000122
8961

**Na
me**

Mr.
SATHAI
AH
EMBADI
..

**Patient
Identifier**

ARHIP55097

Age

63Yr
0Mth
3Days

Sex

Male

**Date
of
Admis
sion**

16-
Mar-
2022

**Date of
Discharge
MLC No**

17-Mar-2022

Address

ANKTHPALLI,LUXETIPET,MANCHERIAL,T
elangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U3

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE

NON-ST ELEVATION MYOCARDIAL INFARCTION
SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

R/F HTN

CORONARY ANGIOGRAM DONE ON 17/03/2022 - CAD-DVD (LAD,RCA)

PLAN CABG WITH GRAFT TO MID LAD, DISTAL RCA

C/o chest pain radiating to left arm associated with sweating and shortness of
breath, vomitings

At Admission

Afebrile

PR: 88/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 63 years old male patient Mr. SATHAIAH EMBADI came with c/o chest pain radiating to left arm associated with sweating and shortness of breath, vomitings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], R/F HTN, CORONARY ANGIOGRAM DONE ON 17/03/2022 - CAD-DVD (LAD,RCA) , PLAN CABG WITH GRAFT TO MID LAD, DISTAL RCA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001228
781

**Na
me**

Mr. BAIRAGI
SATHAIAH

**Patient
Identifier**

ARHIP55051

Age

52Yr
1Mth
11Da
ys

Sex

Male

**Date of
Admission**

12-
Mar-
2022

**Date of
Discharge
MLC No**

12-Mar-2022

Address

18-6-94, KALYAN NAGAR,
GODAVARIKANI,RAMAGUNDA
M,
PEDDAPALLI,Karimnagar,Tela
ngana

Ward/Bed No

First
Floor,
Day
Care,
Bed
no:D
C 2

**Primary
Consultant
Surgeons**

Dr. Vidya Sagar A--
CARDIOLOGY
Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

**Anesthesiolo
gists**

Diagnosi
S

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE UNSTABLE ANGINA. MODERATE LV SYSTOLIC DYSFUNCTION EF:38%. RF:HYPERTENSION,DIABETIC MELLITUS, CORONARY ANGIOGRAM DONE ON 12/03/2022-CAD- DVD(LCX&RCA) PLAN:PTCA+DES TO RCA MEDICAL MANAGEMENT FOR OMS	

C/o Chest pain since 2 months

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 74/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 52 years old male patient Mr. BAIRAGI SATHAIAH came with c/o chest pain since 2 months. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE UNSTABLE ANGINA, MODERATE LV SYSTOLIC DYSFUNCTION EF:38%, RF:HYPERTENSION,DIABETIC MELLITUS, CORONARY ANGIOGRAM DONE ON 12/03/2022-CAD-DVD(LCX&RCA), PLAN:PTCA+DES TO RCA, MEDICAL MANAGEMENT FOR OMS. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
 2. TAB. CLOPILTAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
 3. TAB. ROSUVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
 4. TAB. TELMA-CT 40/12.5MG ONCE DAILY AT 8AM TO CONTINUE.
 5. TAB: EMBETA-XR 25MG ONCE DAILY AT 2PM TO CONTINUE.
 6. TAB: GLYCOMET-SR 850 MG ONCE DAILY AT 2PM TO CONTINUE.
 7. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
 8. INJ HUMAN MIXTARD 30/70 20 U S/C AT 8AM, 15 U S/C AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001
228956

Name

Mr.
MAND
A
PARSH
AIAH

**Patient
Identifier**

ARHIP55100

Age

70Y
r
0M
t
h
3Da
ys
17-
Mar
-
202
2

Sex

Male

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

NARAIMHULAPALLE,Sircilla,
a,Telangana

**Ward
/Bed
No**

Firs
t
Floo
r,
SIC
U,
Bed
no:
SIC
U 8

**Primary
Consultant**

Dr. GOUTHAM ROY
(MS(General Surgery

SMALL BOWEL OBSTRUCTION DUE TO OBSTRUCTED INGUINAL HERNIA,
THROMBOCYTOPENIA

C/o pain abdomen since 3 days
H/o constipation since 3 days
Multiple episodes of vomiting since 3 days
No urine output since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 70 years old male patient Mr. MANDA PARSHAIAH came with c/o pain abdomen since 3 days, h/o constipation since 3 days, multiple episodes of vomiting since 3 days, no urine output since 1 day. All necessary investigations were done and diagnosed as SMALL BOWEL OBSTRUCTION DUE TO OBSTRUCTED INGUINAL HERNIA, THROMBOCYTOPENIA. Patient attenders explained the need for surgery. But patient attenders are not willing for surgery, hence patient is being discharged against medical advice.

ARH1.00012286
25

Name

Mr. SRINIVAS
GANGAVELLI

Patient Identifier

ARHIP55006

Age

36Yr
0Mth
1Days
08-Mar-
2022

Sex

Male

Date of Admission

**Expired Date
MLC No**

09-Mar-2022

Address

5-38,
CHOPPADANDI ,Chop
padandi,Telangana

Ward/Bed No

Ground
Floor,
Emergency Ward,
Bed
no:EME 8

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

Surgeons

Dr. Vidya Sagar A--
CARDIOLOGY

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK, THROMBOLIZATION DONE ON 08/03/2022 WITH INJECTION:STREPTOKINASE,MODERATE LV SYSTOLIC DYSFUNCTION EF:40%, CORONARY ANGIOGRAM DONE ON 08/03/2022,CAD-SVD(LAD). PLAN:PTCA+DES TO LAD.	

C/o chest pain since 2 days a/w SOB

AT ADMISSION:

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 36 years old male patient Mr. SRINIVAS GANGAVELLI came with c/o chest pain since 2 days a/w SOB. All necessary investigations were done and diagnosed as

CORONARY ARTERY DISEASE MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK, THROMBOLIZATION DONE ON 08/03/2022 WITH INJECTION:STREPTOKINASE,MODERATE LV SYSTOLIC DYSFUNCTION EF:40%, CORONARY ANGIOGRAM DONE ON 08/03/2022,CAD-SVD(LAD). PLAN:PTCA+DES TO LAD. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 12.11 PM on 09/03/2022.

CAUSE OF DEATH

CARDIAC ARREST SECONDARY TO MYOCARDIAL INFARCTION WITH
CARDIOGENIC SHOCK

ARH1.00012
28403

Name

Mrs.
SALIGA
NTH
SUNITH
A

**Patient
Identifier**

ARHIP54943

Age

62Yr
1Mth
1Days

Sex

Female

**Date of
Admission**

03-
Mar-
2022

**Expired
Date
MLC
No**

04-Mar-2022

Address

26-5-68,
RADAGAMBALA
MANCHERIAL
9063987763,T
elangana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar
A--
CARDIOLOGY

**Consultant
s**

Surgeons

Dr. Vidya Sagar
A--
CARDIOLOGY

Anesthesiologists

Diagnosis



Diagnosis

Disease	Disease Type
CAD NSTEMI,MODERATE LV DYSFUNCTION EF:40%.CAG + PTCA TO LCX ON 03/03/2022.	

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 years old female patient Mrs. SALIGANTH SUNITHA came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CAD NSTEMI, MODERATE LV DYSFUNCTION EF:40%. CAG + PTCA TO LCX ON 03/03/2022. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 07.35 AM on 04/03/2022.

CAUSE OF DEATH

CAD NSTEMI, MODERATE LV DYSFUNCTION

ARH1.000
1228763

Name

Mrs. G
MAHES
HWARI

**Patient
Identifier**

ARHIP55041

Age

24Y
r
0Mt
h
4D
ays
11-
Mar
-
202
2

Sex

Female

**Date of
Admission**

**Expired
Date
MLC
No**

15-Mar-2022

Address

B.B.
RAJPALLY, Karimnaga
r, Telangana

**Ward/Bed
No**

Firs
t
Flo
or,
MIC
U,
Bed
no:
MIC
U 5

**Primary
Consultant**

Dr. RAMCHANDER
TORREM(MD
(General
Medicine), DM
Nephrology(NIMS), As
sociate Consultant-

Consultants

	Nephrologist)-- NEPHROLOGY	
Surg eons		Anesthesi ologists
	Diagnosi S	
Diagnosis		
	Disease	Diseas e Type
	DELIBARATE SELF HARM PARAQUAT POISONING.	

Alleged history of consumption of **paraquat** pesticide poison 7-100 ml at 3 p.m. in her residence followed by vomitings

AT ADMISSION:

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 24 years old female patient Mrs. G MAHESHWARI came with alleged history of consumption of **paraquat** pesticide poison 7-100 ml at 3 p.m. in her residence followed by vomiting . All necessary investigations were done and diagnosed as DELIBARATE SELF HARM PARAQUAT POISONING. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 05.33 AM on 15/03/2022.

CAUSE OF DEATH

DELIBARATE SELF HARM PARAQUAT POISONING

ARH1.0001
228825

Name

Mrs.
MARU
PAKA
LACHA
VVA

**Patient
Identifier**

ARHIP55054

Age

30Yr
0Mth
7Days

Sex

Female

**Date
of
Admission**

13-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

CHEKKAPALLI,VEMULAWADA,
RAJANNA
SIRCILLA,Telangana

**Ward
/Bed
No**

First
Floor,
CICU,
Bed
no:C
ICU9

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR

MODERATE LV DYSFUNCTION, EF-45%

R/F: HTN

CORONARY ANGIOGRAM DONE ON 17/03/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 2.75 X 37 MM METAFOR DONE ON 17/03/2022

C/o chest pain a/w sweatings since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 30 years old female patient Mrs. MARUPAKA LACHAVVA came with c/o chest pain a/w sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-45%, R/F: HTN, CORONARY ANGIOGRAM DONE ON 17/03/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 2.75 X 37 MM METAFOR DONE ON 17/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. NEWTEL-H 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55085 A NARSAIAH 59

CORONARY ARTERY DISEASE, ANTERIOR LATERAL WALL MI, NO TLT, SR
MODERATE LV DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 16/03/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR DONE ON 16/03/2022
R/F: T2DM, TOBACCO CHEWING

C/o chest pain a/w SOB, sweatings since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 59 years old male patient Mr. NARSAIAH came with c/o chest pain a/w SOB, sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR LATERAL WALL MI, NO TLT, SR, MODERATE LV DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 16/03/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 19 MM METAFOR DONE ON 16/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET-XL 75MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RECLIDE-MR 30 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. GLYCOMET-SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00011721
79 EDIT

Name

Mr. G
RAJIAH

Patient Identifier

ARHIP55031

Age

58Yr
0Mth
23Days

Sex

Male

Date of Admission

10-Mar-2022

**Date of Discharge
MLC No**

Address

thadicherla, dist:
jayashnakar, Warangal, Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
2

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

S/P POST PTCA DONE ON 2019

CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-TVD (Left Dominant system)

PTCA+DES TO LAD, PLV (Two stents) WITH 3.0 X 16 MM METAFOR TO LAD, 2.75 X 13 MM METAFOR TO PLV DONE ON 16/03/2022
R/F: HYPERTENSION

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 85/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. G RAJAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, S/P POST PTCA DONE ON 2019, CORONARY ANGIOGRAM DONE ON 14/03/2022 - CAD-TVD (Left Dominant system), PTCA+DES TO LAD, PLV (Two stents) WITH 3.0 X 16 MM METAFOR TO LAD, 2.75 X 13 MM METAFOR TO PLV DONE ON 16/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ANGISPAN-TR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. MUCINAC 600 MG THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
- 7) TAB. FEBUTAZ 40 MG ONCE DAILY AT 2PM TO CONTINUE.
- 8) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
28925

Name

Mr.
SAMBA
IAH B

**Patient
Identifier**

ARHIP55092

Age

46Yr
0Mth
4Days

Sex

Male

**Date
of
Admission**

16-
Mar-
202
2

**Date
of
Discharge
MLC
No**

Address

11-2-396 8 LINCLINE
COLONY,Karimnagar,T
elangana

**Ward/
Bed
No**

Sec
ond
Floor,
Male
General
Ward,
Bed
no:
GW
12

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, NSTEMI

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (19/03/2022) -CAD-Mild LAD, RCA disease

PLAN MEDICAL MANAGEMENT

C/o slurring of speech, weakness of right upper limb, lower limb since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. SAMBAIAH came with c/o slurring of speech, weakness of right upper limb, lower limb since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (19/03/2022) -CAD-Mild LAD, RCA disease, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: STARPRESS-R-XL 50MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012
28885

Name

Mr.
NARSA
IAH
GADA
M

**Patient
Identifier**

ARHIP55079

Age

56Yr
0Mth
5Days

Sex

Male

**Date
of
Admission**

15-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

6-6-28
NULLKARKHANA
GADAM,Karimnagar,T
elangana

**Ward/
Bed
No**

First
Floor,
HDU
, Bed
no:HDU
3

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE , NSTEMI,

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

R/F DM, HTN, TOBACCO ADDICT, ALCOHOL

CORONARY ANGIOGRAM DONE ON 27/10/2016 - CAD-2VD (LCX, RCA)

ADV: PTCA+DES TO RCA

MEDICAL MANAGEMENT FOR LCX

PP: CORONARY ARTERY DISEASE , EVOLVED AWM, MILD MR, SR

SEVERE LV DYSFUNCTION, EF-25%

CORONARY ANGIOGRAM DONE ON 15/03/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

C/o chest pain since 1 week a/w shortness of breath

At Admission

Afebrile

PR: 107/min

BP: 90/60 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-94%

A 56 years old male patient Mr. NARSAIAH GADAM came with c/o chest pain since 1 week a/w shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, R/F DM, HTN, TOBACCO ADDICT, ALCOHOL, CORONARY ANGIOGRAM DONE ON 27/10/2016 - CAD-2VD (LCX, RCA), ADV: PTCA+DES TO RCA, MEDICAL MANAGEMENT FOR LCX, PP: CORONARY ARTERY DISEASE , EVOLVED AWTMI, MILD MR, SR, SEVERE LV DYSFUNCTION, EF-25%, CORONARY ANGIOGRAM DONE ON 15/03/2022 - CAD-TVD (LAD, LCX, RCA), PLAN CABG. CTVS DR. SOMASHEKAR sir consultation taken and adviced for myocardial perfusion scan to know viability and feasibility of surgery. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. TELMA-H 40 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. AXEGLIPTIN 500 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. GLYMIACE-M1 500 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

ADVISED FOR MYOCARDIAL PERFUSION SCAN

FOLLOWUP AFTER THIS TEST

ARH1.0001 073537		N a m e	Mrs. KAMALA BATULA
Patient Identifier	ARHIP55072	Age	69Yr 1Mth 25Days
Sex	Female	Date of Admission	14-Mar-2022
Expired Date	19-Mar-2022		
MLC No			
Address	JAVAHARNAGAR,Karimnagar, Telangana	Ward/Bed No	First Floor, SICU, Bed no:SICU 4
Primary Consultant	Dr. Venkat Reddy Almareddi (MS(Orthopaedics),MBA(Healthcare),Fellow in Joint Replacement,Fellow in Shoulder Surgery(USA),Fellow in Arthroscopy(SIOR),Consultant Orthopaedic Surgeon)-- ORTHOPAEDICS	Consultants	

Surgeons

Dr. Venkat Reddy Almareddi
(MS(Orthopaedics),MBA(Healthcare),Fellow in Joint Replacement,Fellow in Shoulder Surgery(USA),Fellow in Arthroscopy(SIOR),Consultant Orthopaedic Surgeon)--
ORTHOPAEDICS

Anesthesiologists

Dr Subba Reddy
Kuppannagari
--
ANAESTHESIOLOGY

Diagnosis**Diagnosis**[Add Diagnosis](#)

Disease	Disease Type
Fracture olecranon right	Pd

Patient alleged h/o fall at home on 12/03/2022

C/o pain and swelling in right elbow

AT ADMISSION:

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 69 years old female patient Mrs. KAMALA BATULA came with patient alleged h/o fall at home on 12/03/2022, c/o pain and swelling in right elbow. All

necessary investigations were done and diagnosed as Fracture olecranon right, S/P: Plating of olecranon done on 18/03/2022 . Patient condition and prognosis was explained to patient attendants, patient was ionotropic support. On 19.03.2022 at 6.45 AM patient had become unresponsive, immediately CPR started according to ACLS guidelines. inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 09.26 AM on 19/03/2022

CAUSE OF DEATH

CARDIOGENIC SHOCK

54784

CORONARY ARTERY DISEASE , ACUTE AAWMI

SEVERE LV DYSFUNCTION,

COPD

R/F HTN, SMOKING ALCOHOL

S/P CORONARY ANGIOGRAM DONE ON 30/04/2022 - CAD-DVD

ARH1.000122 7870	Name	Mrs. MATCHA SAROJAM MA	
Patient Identifier	ARHIP54784	Age	75Y r 1Mt h 1Da ys 18- Feb - 202 2
Sex	Female	Date of Admission	
Date of Discharge	19-Feb-2022		
MLC No			
Addresses	SIRPUR BALAJI NAGAR ,Nirm	Ward/Bed No	Firs t Flo

al,Telangana

Primary Consultant Surgeons

Dr. Vidya Sagar A--
CARDIOLOGY

Dr. Vidya Sagar A--
CARDIOLOGY

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
CAD-NSTEMI WITH ACCELERATED HYPERTENSION. SR,MODERATE LV DYSFUNCTION. CAD-OLD AWTI.S/P-PTCA+DES TO LAD IN 2021. R/F-HYPERTENSION,TYPE 2 DIABETES MELLITUS. S/P-CAG (19/02/2022)-SVD(PROXIMAL LAD SIGNIFICANT ISR). ADVICE-EARLY CABG	

C/o Retrosternal chest pain a/w sweating since 2-3 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 75 years old female patient Mrs. MATCHA SAROJAMMA came with c/o Retrosternal chest pain a/w sweating since 2-3 days. All necessary investigations were done and diagnosed as CAD-NSTEMI WITH ACCELERATED HYPERTENSION, SR, MODERATE LV DYSFUNCTION, CAD-OLD AWM. S/P-PTCA+DES TO LAD IN 2021, R/F-HYPERTENSION, TYPE 2 DIABETES MELLITUS, S/P-CAG (19/02/2022)-SVD (PROXIMAL LAD SIGNIFICANT ISR), ADVICE- EARLY CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. RAMISTAR 5 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

APJ1.00020
50050

Name

Mr.
GANDU
RAMMU
RTHY

**Patient
Identifier**

ARHIP55083

Age

51
Yr
9M
th
16
Da
ys
15-
Ma
r-
20
22

Sex

Male

**Date
of
Admission**

**Date
of
Discharge
MLC
No
Address**

THEEGALAGUTAPALLY(MONDAL
,Karimnagar

CHRONIC RHEUMATIC HEART DISEASE

PERCUTANEOUS BALLOON MITRAL VALVOTOMY

PBMV (1996)

AF WITH FVR

R/F: HYPERTENSION, DIABETES MELLITUS, HYPOTHYROIDISM

ATRIAL FLUTTER WITH ABERRANCY

DC SHOCK 100J REVERTED TO NSR

C/o Shortness of breath since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 51 years old male patient Mr. GANDU RAMMURTHY came with c/o Shortness of breath since 1 day. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE, PERCUTANEOUS BALLOON MITRAL VALVOTOMY, PBMV (1996), AF WITH FVR, R/F: HYPERTENSION, DIABETES MELLITUS, HYPOTHYROIDISM, ATRIAL FLUTTER WITH ABERRANCY, DC SHOCK 100J given, reverted to NSR. Patient had elevated blood sugar levels, managed with insulin as per sliding scale. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. LANOXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE 5DAYS IN A WEEK
2. TAB. SOTALOR 40 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
3. TAB. ACITROM 2MG & 3MG ALTERNATE DAY AT 4PM TO CONTINUE.
4. TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD ECG,FBS, PLBS & PT-INR.

ARH1.0001229084

Name

Mr. ALLAM
DEVENDER

**Patient
Identifier**

ARHIP55135

Age

44Yr 0Mth
1Days

Sex

Male

**Date of
Admission**

21-Mar-
2022

**Date of
Discharge
MLC No**

Address

Nehru
Nagar,Sircilla,Telanga
na

**Ward/
Bed No**

Ground
Floor,
Emergenc
y Ward,
Bed
no:EME2

**Primary
Consultant**

Dr. GOUTHAM ROY
(MS)

DUODENAL PERFORATION WITH HAEMOPERITONEUM SECONDARY TO BLUNT
ABDOMINAL TRAUMA,
LEFT DISTAL TIBIA, FIBULA FRACTURE

Alleged history of road traffic accident 4 wheeler vs divider at 4 p.m. on 20/03/22

AT ADMISSION:

Afebrile

PR: 92/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Treated with
Iv fluids
Inj Tramadol
Inj Pan
Inj Zofer
Inj Buscopan
Inj Metrogyl
Inj Morphine

A 44 years old male patient Mr. ALLAM DEVENDER came with alleged history of road traffic accident 4 wheeler vs divider at 4 p.m. on 20/03/22. All necessary investigations were done and diagnosed as DUODENAL PERFORATION WITH HAEMOPERITONEUM SECONDARY TO BLUNT ABDOMINAL TRAUMA, LEFT DISTAL TIBIA, FIBULA FRACTURE. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is getting discharged against medical advice.

ARH1.00012
28976

EDIT

Name

Mr. K
NARAY
ANA

**Patient
Identifier**

ARHIP55108

Age

70Yr
0Mth
6Days

Sex

Male

**Date
of
Admission**

17-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

DWARAKA,
MANCHERYAL, Karimnagar,
Telangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no: CIC
U12

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE

ANTERIOR SEPTAL WALL MYOCARDIAL INFARCTION
NORMAL LV SYSTOLIC FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 21/03/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 21/03/2022
R/F HYPERTENSION, DIABETES MELLITUS, SMOKER

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70 years old male patient Mr. K NARAYANA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR SEPTAL WALL MYOCARDIAL INFARCTION, NORMAL LV SYSTOLIC FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 21/03/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 32 MM 3V ASTRA DONE ON 21/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CILODOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. BETALOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. CARDANONE-X 200 MG THRICE DAILY AT 8AM, 2PM AND 8PM TO CONTINUE.
- 7) TAB. MINIPRESS-XL 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. TOR 5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 9) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
29123

Name

Mrs.
GANDE
BHAGYAL
AXMI

**Patient
Identifier**

ARHIP55144

Age

80Yr
0Mth
2Days

Sex

Female

**Date
of
Admission**

21-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

KATLAKUNTA
METPALLI
JAGITIAL, Karimnagar, T
elangana

**Ward/
Bed
No**

First
Floor,
CICU
, Bed
no:CI
CU3

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE,

ANTERIOR WALL MYOCARDIAL INFARCTION

R/F : HYPERTENSION

SEVERE LV DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM (22/03/2022) -CAD-LM+TVD (LAD, LCX, RCA)

PLAN : CABG+MVR

C/o chest pain, SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 80 years old female patient Mrs. GANDE BHAGYALAXMI came with c/o chest pain, SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MYOCARDIAL INFARCTION, R/F : HYPERTENSION, SEVERE LV DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM (22/03/2022) -CAD-LM+TVD (LAD, LCX, RCA), PLAN : CABG+MVR. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 20MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CARDACE 2.5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012
29081

Name

Mrs.
VAVIL
ALA
VIMAL
A

**Patient
Identifier**

ARHIP55131

Age

65Yr
0Mth
3Days

Sex

Female

**Date
of
Admission**

20-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

Timmapur,Karimnagar,T
elangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

AF WITH FVR

CHRONIC RHEUMATIC HEART DISEASE, SEVERE MR

NORMAL LV SYSTOLIC FUNCTION, EF-60%

R/F : HYPERTENSION

C/o severe shortness of breath
H/o bilateral pedal edema

K/c/o Hypertension on regular medication

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 65 years old female patient Mrs. VAVILALA VIMALA came with c/o severe shortness of breath, h/o bilateral pedal edema. All necessary investigations were done and diagnosed as AF WITH FVR, CHRONIC RHEUMATIC HEART DISEASE, SEVERE MR, NORMAL LV SYSTOLIC FUNCTION, EF-60%. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. CARDANONE-X 200 MG ONCE DAILY AT 8AM TO CONTINUE.
- 2) TAB. FRUSELAC-DS ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ACITROM 1 MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH PT-INR report

ARH1.000122
9124

Name

Mr.
GANGAR
AM
ADIPELLI

**Patient
Identifier**

ARHIP55143

Age

56Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

21-
Mar-
2022

**Date of
Discharge
MLC No**

Address

5-30, KATHALAPUR
JAGTIAL, Other, Telan
gana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MI
CU 4

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE,

INFERIOR WALL MI

MILD LV SYSTOLIC DYSFUNCTION, EF 45%

CORONARY ANGIOGRAM (23/03/2022) -CAD-SVD (RCA)

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain since 19/03/2022

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 72/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96% on room air

P/A: Soft

A 56 years old male patient Mr. GANGARAM ADIPELLI came with c/o Retrosternal chest pain since 19/03/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, INFERIOR WALL MI, MILD LV SYSTOLIC DYSFUNCTION, EF 45%, CORONARY ANGIOGRAM (23/03/2022) -CAD-SVD (RCA), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. ACITROM 1 MG ONCE DAILY AT 7PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229
125

**Na
me**

Mr.
VENKATES
H INDURI

**Patient
Identifier**

ARHIP55142

Age

45Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

21-
Mar-
2022

**Date of
Discharge
MLC No**

Address

5-7,
LAXMIPUR,LAXXETIPET,MANCHIRAIL,Tela
ngana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MI
CU 5

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ANTERIOR WALL MI

MILD LV DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM (23/03/2022) -CAD-LM+TVD (LAD, LCX,RCA)

PLAN CABG WITH GRAFT TO LAD, RAMUS, OM, PDA

C/o Sudden onset of chest pain since 18/03/2022

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98% on room air

P/A: Soft

A 45 years old male patient Mr. VENKATESH INDURI came with c/o Sudden onset of chest pain since 18/03/2022. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MI, MILD LV DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM (23/03/2022) -CAD-LM+TVD (LAD, LCX,RCA), PLAN CABG WITH GRAFT TO LAD, RAMUS, OM, PDA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.00012269
04

Name

Mrs. BANDA
PRAVALLIKA

**Patient
Identifier**

ARHIP55150...

Age

21Yr
2Mth
3Days

Sex

Female

**Date of
Admission**

23-Mar-
2022

**Date of
Discharge
MLC No**

Address

KYATHAN PALLI
MACNHERIYAL,Mancherial,Telang
ana

**Ward/Bed
No**

First
Floor,
SICU, Bed
no:SICU1
2

**Primary
Consultant**

Dr. GOUTHAM ROY (MS)

RIGHT LUMBAR LYMPHANGIOMA

SURGERY: RIGHT LUMBAR LYMPHANGIOMA EXCISION DONE ON 23/03/2022

C/o pain and swelling over lumbar region right side since 2 months

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

Afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 21yr old female patient Mrs. BANDA PRAVALLIKA came with c/o pain and swelling over lumbar region right side since 2 months. All necessary investigations done and diagnosed as RIGHT LUMBAR LYMPHANGIOMA, SURGERY: RIGHT LUMBAR LYMPHANGIOMA EXCISION DONE ON 23/03/2022. Findings: Large lymphangioma noted in the lumbar region in the superior plain above the external ostium muscle measuring 12 x 15 cm noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: FAMOCID 40 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

Venkateswarlu 55164

APJ1.00024913
48

Name

Mr. K
VENKATESHWARULU

Patient Identifier

ARHIP55164

Age

60Yr
9Mth
14Days

Sex

Male

Date of Admission

24-Mar-2022

Date of Discharge MLC No

24-Mar-2022

Address

h no 2-44
uttoruttor ,manakondur,Karimnagar,Telangana

Ward/Bed No

First Floor,
Day Care,
Bed no:DC 2

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

S/P PTCA TO D1 21/03/2016

TMT +VE ON 05/10/2021

CORONARY ANGIOGRAM (24/03/2022) -CAD-SVD

PLAN PTCA+DES TO LAD

R/F : HYPERTENSION

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. K VENKATESHWARULU came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, S/P PTCA TO D1 21/03/2016, TMT +VE ON 05/10/2021, CORONARY ANGIOGRAM (24/03/2022) -CAD-SVD, PLAN PTCA+DES TO LAD. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PROLOMET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. TAZLOC 40MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. NIKORAN 5MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

Venkat reddy 55116 60

ARH1.0001
229025

Name

Mr.
OGUL
APU
VENK
AT
REDD
Y

**Patie
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Identi
fier**

ARHIP55116

Age

60
Yr
9M
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19-
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20
22

Sex

Male

**Date
of
Admi
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**Date
of
Disch
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MLC
No**

**Addr
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4-
121/5,CHEL GAL,JAGTIAL,Karimna
gar,Telangana

**Ward
/Bed
No**

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DR. SRI KARAN UDDESH --
INTERNAL

ACUTE TYPE-II RESPIRATORY FAILURE
SEPTIC SHOCK
ACUTE KIDNEY INJURY (POST 1 CYCLE OF SLED)
NOW ONSET DIABETIC MELLITUS

Bronchial asthma, hypertension, recently diagnosed DM

H/o Unresponsiveness since is 6:30 a.m.

H/o Fever since 2 days

AT ADMISSION:
Patient comatose
PR: 96/min
BP not recordable, on Noradrenaline 5 ml/hr
RS: B/l wheeze+
CVS: S1S2

SPO2: 96% on mechanical ventilator
P/A: Soft
GCS 6/15
CBG -215 mg/dL

A 60-year-old male patient Mr. OGULAPU VENKAT REDDY presented with the above-mentioned complaints. Patient was diagnosed to have acute exacerbation of bronchial asthma with septic shock patient was treated with IV fluids INJ. MEROPENEM 1 gm according to creatinine clearance. INJ. Methylpred 60 mg IV 1-0-1 for 5 days, Nebulisation DUOLIN and BUDECORT. Patient was intubated in view of poor GCS over the next 48 hours of hospitalization. Patient's clinical status improved and patient was weaned off mechanical ventilator. Patient had acute kidney injury with oliguria. Nephrology consultation was taken and 1 cycle of SLED was done. Patient improved clinically following SLED, patient no longer required inotropic support. Now the patient is haemodynamically stable and is being discharged with following advice.

DISCHARGE MEDICATION:

1. SYP. LACTIHEP 15 ML ONCE DAILY AT 9 P.M.
2. SEROFLO INHALER 2 PUFFS TWICE IN A DAY AT 8AM AND 8 P.M. FOR 14 DAYS
3. TAB. PANTOCID 40 MG ONCE IN A DAY AT 7AM FOR 14 DAYS
4. TAB. TELMA 20 MG ONCE IN A DAY AT 8AM FOR 14 DAYS
5. TAB. VILDA M 50/500 TWICE IN A DAY AT 8AM AND 8 P.M. FOR 14 DAYS

REVIEW AFTER 14 DAYS WITH FBS, PLBS REPORTS TO GENERAL MEDICINE OPD.

ARH1.00012 29193		Name	Mr. RAVIN DER GANDL A
Patient Identifier	ARHIP55163	Age	37Yr 0Mth 3Days
Sex	Male	Date of Admission	24- Mar- 2022
Date of Discharge MLC No			
Address	H.NO:2- 80,THEEGALAGUTTAPALLY,KARIMNAGAR,Karimn agar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CIC U10
Primary Consultant	Dr. Vidya Sagar A		

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR
 NORMAL LV FUNCTION [EF-60%]
 CORONARY ANGIOGRAM (24/03/2022) -CAD-Recanalized LCX
 PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 37 years old male patient Mr. RAVINDER GANDLA came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (24/03/2022) - CAD-Recanalized LCX, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.000
1218325

Name

Mr.
BOYI
NI
SAM
MAIA
H

**Pati
ent
Iden
tifie
r**

ARHIP55152

Age

51Y
r
2Mt
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25
Day
s

Sex

Male

**Dat
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Adm
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23-
Mar
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202
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**Date
of
Disc
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MLC
No**

**Add
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YERADAPALLY,SHANKARAPATNAM,Ka
rimnagar,Telangana

**War
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Bed
No**

Firs
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Flo
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CIC
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Bed
no:
CIC
U3

**Prim
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Dr. Vidya Sagar A--CARDIOLOGY

LEFT VENTRICULAR FAILURE
MODERATE MR, GLOBAL HYPOKINESIA OF LV
SEVERE LV SYSTOLIC DYSFUNCTION EF -25%
R/F: ALCOHOL

C/o chest pain a/w Shortness of breath since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 51 years old male patient Mr. BOYINI SAMMAIAH came with c/o chest pain a/w Shortness of breath since 2 days. All necessary investigations were done and diagnosed as LEFT VENTRICULAR FAILURE, MODERATE MR, GLOBAL HYPOKINESIA OF LV, SEVERE LV SYSTOLIC DYSFUNCTION EF -25%, R/F: ALCOHOL. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
4. TAB. RAMISTAR 2.5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. ALDACTONE 25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
6. TAB. BENALGIS 100 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012
29194

Name

Mr.
SRINIV
AS
RAO S

**Patient
Identifier**

ARHIP55165

Age

56Yr
7Mth
18Days

Sex

Male

**Date
of
Admission**

24-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

ntpc
jothinagar,Karimnagar,T
elangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFARCTION
NO TL T SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%
CORONARY ANGIOGRAM (24/03/2022) -CAD-LM+TVD (LAD, LCX, RCA)

PRIMARY PTCA+DES TO LAD WITH XIENCE XPEDITION 3.0 X 28 mm DONE ON
24/03/2022

PTCA+DES TO LCX & RCA LATER

R/F: HYPERTENSION

C/o sudden onset chest pain a/w sweating

K/C/O HYPERTENSION

AT ADMISSION:

Afebrile

PR: 72/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 56 years old male patient Mr. SRINIVAS RAO S came with c/o sudden onset chest pain a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFARCTION, NO TL T SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM (24/03/2022) -CAD-LM+TVD (LAD, LCX, RCA), PRIMARY PTCA+DES TO LAD WITH XIENCE XPEDITION 3.0 X 28 mm DONE ON 24/03/2022, PTCA+DES TO LCX & RCA LATER. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. BRILINTA 90MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. BETALOC 25MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB: VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012290
77

**Nam
e**

Mr.
SHANKARAIA
H
SUNKAPAKA

**Patient
Identifier**

ARHIP55132

Age

52Yr
0Mth
6Days

Sex

Male

**Date of
Admission**

20-Mar-
2022

**Date of
Discharge
MLC No**

Address

H.NO:6-
64,VILASAGAR,BOINPALLY,RAJANN
A SIRICILLA,Other,Telangana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
7

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR
MILD LV SYSTOLIC DYSFUNCTION, EF-40%
CORONARY ANGIOGRAM (23/03/2022) -CAD-SVD (LAD)

PTCA+DES TO LAD WITH METAFOR 3.0 X 19 mm DONE ON 23/03/2022

R/F: DM

C/o chest pain a/w SOB since 1 day

K/C/O DM

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 52 years old male patient Mr. SHANKARAIAH SUNKAPAKA came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM (23/03/2022) -CAD-SVD (LAD), PTCA+DES TO LAD WITH METAFOR 3.0 X 19 mm DONE ON 23/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PRASUDOC 10MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CONCOR COR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

.000114
3129

**Patient
Identifier**

Name

Mr. CH
LAXMI
NARAYA
NA

ARHIP55151

Age

54Yr
4Mth
26Days

Sex

Male

**Date
of
Admission**

23-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

PORANDLA,Karimnagar,Te
langana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U12

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR
NORMAL LV FUNCTION, EF-65%
CORONARY ANGIOGRAM (25/05/2022) -CAD-DVD

PLAN: CABG

C/o chest pain on and off since 2 months

AT ADMISSION:

Afebrile

PR: 101/min

BP: 110/60 mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 100%

P/A: Soft

A 54 years old male patient Mr. CH LAXMI NARAYANA came with c/o chest pain on and off since 2 months. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV FUNCTION, EF-65%, CORONARY ANGIOGRAM (25/05/2022) -CAD-DVD, PLAN: CABG. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. STARPRESS-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. TELMA-H 40MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001
227984

Name

Mrs.
MAHAMAD
KATHEJAB
EGAM

**Patient
Identifier**

ARHIP55105

Age

43
Yr
0
Mth
8Days
17
-
Mar-
20
22

Sex

Female

**Date
of
Admission**

**Date
of
Discharge
MLC
No**

Address

5-68/4,
KALESHWARA
M
JAYASHANKAR
,Karimnagar,T
elangana

**Ward
/Bed
No**

Fir
st
Floor,
CT
POST
,
Bed
no
:CT
4

**Primary
Consultant**

Dr
SOMASHEKAR
K(MS,MCH

CHRONIC RHEUMATIC HEART DISEASE WITH SEVERE MITRAL STENOSIS

SURGERY: MITRAL VALVE REPLACEMENT WITH SJ NO. 27 mm, MECHANICAL VALVE DONE ON 24/03/2022.

C/o SOB on exertion a/w palpitations since 7 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old female patient Mrs. MAHAMAD KATHEJABEGAM came with c/o SOB on exertion a/w palpitations since 7 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE WITH SEVERE MITRAL STENOSIS, SURGERY: MITRAL VALVE REPLACEMENT WITH SJ NO. 27 mm, MECHANICAL VALVE DONE ON 24/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, NORMAL FUNCTIONING PROSTHETIC MV, NO VALVULAR/PARAVALVULAR LEAK, NO LV RWMA, MILD MR, minimal PE, No Clot/Veg

BMI is 21.9 kg/m².

Sr. Creatinine report done on 25.03.2022 0.9 mg/dl

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 8AM FOR 11 DAYS
- 4) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
- 5) TAB. DOLO 650MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 6) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

PatientDetails

UHID Patient Identifier	ARH1.0001228499 ARHIP55095	Name	Mrs. ERAVENI VENKAVVA
Sex	Female	Age	55Yr 2Mth 24Days
Date of Discharge		Date of Admission	16-Mar-2022
MLC No		Ward/ Bed No	First Floor, CT POST, Bed no:CT 3
Address	4-32, NANCHERLA JAGTIAL ,Karimnagar,Telangana		
Primary Consultant	Dr SOMASHEKAR K(

CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+ SEVERE MITRAL REGURGITATION+HYPERTENSION

Surgery: CORONARY ARTERY BYPASS GRAFTING (SVG TO LAD, OM, PDA) + MITRAL VALVE REPLACEMENT WITH SJ NO 25 MM MECHANICAL VALVE DONE ON 23/03/2022).

C/o chest pain a/w SOB, palpitations since 10 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. ERAVENI VENKAVVA came with c/o chest pain a/w SOB, palpitations since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+TRIPLE VESSEL DISEASE+ SEVERE MITRAL REGURGITATION+HYPERTENSION, **Surgery:** CORONARY ARTERY BYPASS GRAFTING (SVG TO LAD, OM, PDA) + MITRAL VALVE REPLACEMENT WITH SJ NO 25 MM MECHANICAL VALVE DONE ON 23/03/2022). Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice.

POST CABG+MVR 2D ECHO REPORTS SHOWED: PROSTHETIC VALVE INSITU, NORMAL FUNCTIONING PROSTHETIC MV, NO VALVULAR/PARAVALVULAR LEAK, NO LV RWMA, MILD MR/AR, NO PE/CLOT/VEG

BMI is 18.8 kg/m².

Sr. Creatinine report done on 24.03.2022 1.2 mg/dl

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 1 MG & 2 MG ALTERNATE DAY AT 7PM TO CONTINUE LIFE LONG.
- 2) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. TIGATEL 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.
- 8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR REPORTS

ARH1.0001 219558	Name	Baby SPOO RTHI VAVIL ALA	
Patient Identifier	ARHIP55214	Age	13Y r 5Mt h 7Da ys
Sex	Female	Date of Admission	28- Mar - 202 2
Date of Discharge MLC No	28-Mar-2022		
Address	1-2 DHARMAPURI, Karimnaga r, Telangana	Ward/Bed No	Firs t Floo r, SIC U, Bed no: SIC U 7
Primary Consultant Surgeons	Dr SRINIVAS L--GENERAL SURGERY	Consultants	
		Anesthesiologists	
	Diagnosis		

Diagnosis

Disease	Disease Type
ACUTE GASTROENTERITIS.	Pd

ACUTE GASTROENTERITIS

C/o sudden onset of pain and burning sensation in abdomen since 1 day
History of 6 episodes of vomitings+

Known case of PTA + stent to aorta

S/P right iliac femoral arterial bypass grafting

AT ADMISSION:

Afebrile

PR: 90/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

GRBS-106 mg/dl

Treated with

INJ. MONOCEF 1 g IV 1-0-1

INJ. METROGYL 500 mg IV 1-1-1

INJ. KETOROLAC 1 amp IV 1-0-1

INJ. ZOFER 4 mg IV 1-1-1

SYP. DULCOLAX 10 mL 1-0-1

A 13 years old Baby SPOORTHY VAVILALA came with c/o sudden onset of pain and burning sensation in abdomen since 1 day, history of 6 episodes of vomitings+. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS. Managed conservatively. Patient referring to Higher Centre for further management for subacute small bowel obstruction with high risk.

55217 RAJESWAR

ARH1.00012
29396

Name

Mr. K
RAJESH
WAR
RAO

**Patient
Identifier**

ARHIP55217

Age

70Yr
0Mth
1Days

Sex

Male

**Date
of
Admission**

28-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

ELLAMPALLY,,Karimnagar,
Telangana

**Ward/
Bed
No**

First
Floor
,
MICU,
Bed
no:M
ICU
12

**Primary
Consultant**

DR. SRI KARAN UDDESH

C/o dyspnoea grade-III since few days

Known case of right fibrothorax
Known case of COPD

AT ADMISSION:

Afebrile

PR: 115/min

BP: 130/70mmHg

Lungs: Reduced air entry

CVS: S1S2

RR: 20/min

SPO2: 98% with 2 Lit O2

P/A: Soft

A 70 years old male patient Mr. K RAJESHWAR RAO presented with the above-mentioned complaints. Patient was diagnosed to have acute heart failure with atrial fibrillation.

Patient was treated with IV diuretics and TAB. AMIODARONE. Patient improved clinically. 2D echo was done which showed severe aortic stenosis and severe MR, CTVS opinion taken. Patient is advised for the stay in hospital, but attendant want discharge, hence patient is being discharged against medical advice.

DISCHARGE MEDICATION:

1. TAB. AMLODIPINE 100 MG ONCE DAILY AT 8 A.M. TO CONTINUE
2. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8 A.M. TO CONTINUE
3. TAB. DABIGATRAN 110 MG TWICE DAILY AT 8 A.M. AND 8 P.M. TO CONTINUE
4. CONTINUE OLD DIABETIC MEDICATION

ARH1.0001229
405

Name

Mrs.
SINDA
M
LAXMI

**Patient
Identifier**

ARHIP55232

Age

52Yr
0M
h
0Da
ys
29-
Mar-
202
2

Sex

Female

**Date of
Admission**

**Date of
Discharge
MLC No**

Address

kasulapalli, peddapalli
mdl, Ramagundam, Telangana

**Ward/
Bed No**

First
Floor,
Day
Care,
Bed
no: DC
3

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

ATYPICAL CHEST PAIN
R/F HYPERTENSION, TOBACCO ADDICT
CORONARY ANGIOGRAM (29/03/2022) -CAD- Proximal LAD mild disease
(Ectatic)
ADVISED MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 65/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old female patient Mrs. SINDAM LAXMI came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, R/F HYPERTENSION, TOBACCO ADDICT, CORONARY ANGIOGRAM (29/03/2022) -CAD- Proximal LAD mild disease (Ectatic), ADVISED MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. TELLZY 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

QUITTE TOBACCO

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001229415		Name	Mr. KANAKAIAH G
Patient Identifier	ARHIP55235..	Age	76Yr 0Mth 1Days
Sex	Male	Date of Admission	29-Mar-2022
Date of Discharge			
MLC No			
Address	NAGARAM, HUSNABAD, SIDDIPET,Karimnagar,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MIC U 10
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

MILD AR/PAH, SR

NORMAL LV SYSTOLIC FUNCTION

R/F : T2DM, HTN

CORONARY ANGIOGRAM (29/03/2022) – Mild CAD (LAD, OM, RCA)

ADV: MEDICAL MANAGEMENT

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 69/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 76 years old male patient Mr. KANAKAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MILD AR/PAH, SR, NORMAL LV SYSTOLIC FUNCTION, R/F : T2DM, HTN, CORONARY ANGIOGRAM (29/03/2022) – Mild CAD (LAD, OM, RCA), ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. METPURE XL 2.5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. VOGS M 0.3/500MG ONCE DAILY BEFORE LUNCH TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001
229392

Name

Mrs.
MADHUN
AMMA G

**Patient
Identifier**

ARHIP55211

Age

62Y
r
2M
h
29
Day
s

Sex

Female

**Date
of
Admission**

28-
Mar
-
202
2

**Date
of
Discharge
MLC
No**

Address

H.NO:1-
71,MADIPALLY,JAMMIKUNTA,KARIMN
GAR,Telangana

**Ward
/Bed
No**

Firs
t
Flo
or,
MIC
U,
Bed
no:
MIC
U 5

**Primary
Consultant**

DR. SRI KARAN UDDESH --INTERNAL
MEDICINE

SEPSIS WITH MODS.

Decreased appetite since 7 days

decreased responsiveness since 2 days

Grade-IV dyspnea since 1 day

AT ADMISSION:

Patient tachypneic, labile orientation

PR: 47/min

BP: Not recordable, on noredrenaline 20 ml/hr, vasopressin 2 cc/hr

RS: BAE+, b/l crackles

CVS: S1S2

RR: 30/min

SPO2: 100% with FIO2 100%

P/A: Soft

GCS-E1, V1, M3

Known case of cervical cancer

Obstructive uropathy

Chronic kidney disease

A 62 years old female patient Mrs. MADHUNAMMA patient presented with the above-mentioned complaints, in view of poor GCS and respiratory distress. Patient was intubated and connected to mechanical ventilator. Dual inotropic support was started to increase blood pressure. Patient was started on INJ. MEROPENEM and antihyperkalaemic measures, INJ. Soda Bicarb was given in view of severe metabolic acidosis. Nephrology consultation was taken and advice was followed, planned SLED if BP improved. Throughout the hospital stay patient's condition did not improve, despite dual inotropic support mean arterial pressure did not improve. On 30.03.2022 at 6.00 AM patient developed bradycardia, CPR initiated according to ACLS guidelines. Despite best efforts patient could not be revived and declared dead at 6.36 AM on 30/03/2022

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH MODS.

ARH1.00012
29120

Name

Mr.
M D
SALE
EM

**Patient
Identifier**

ARHIP55140

Age

35Yr
0Mth
9Days

Sex

Male

**Date of
Admission**

21-Mar-
2022

**Date of
Discharge
MLC
No**

22-Mar-2022

Address

VEGURUPALLI
MANAKONDUR, Karimnagar,
Telangana

**Ward/Bed
No**

First
Floor
,
SICU
,
Bed
no:S
ICU
10

**Primary
Consultant
Surgeons**

Dr. GOUTHAM ROY
(MS(General
Surgery), Consultant
General Surgeon)-
GENERAL SURGERY

Consultants

Anesthesiologists

Diagnosis

Diagnosis



Disease	Disease Type
---------	--------------

RIGHT PNEUMOTHORAX, SURGICAL EMPHYSEMA
THROMBOSIS OF BRACHIAL AND BASILIC VEIN.
??ROTATOR CUFT INJURY
??COMPARTMENT SYNDROME.

Alleged history of road traffic accident paediatrician versus Lorry at 2 p.m., sustained injury to right upper limb and chest
C/o Shortness of breath

AT ADMISSION:

Afebrile

PR: 90/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 24/min

SPO2: 100% with 4 litre of O2

P/A: Soft

Treated with

INJ AMOCTUM 1.5 g IV 1-0-1

INJ PAN 40 mg IV 1-0-0

INJ ZOFRAN 8 mg IV 1-0-1

IV Fluids CNS

INJ TRAMADOL 100 mg IV 1-1-1

INJ LEVOFLOX 500 mg IV 1-0-0

INJ NORADRENALINE 100 ml IV 1-0-0

Nebulisation with DUOLIN and BUDECORT 1-1-1

A 35 years old male patient Mr. M D SALEEM came with alleged history of road traffic accident Paediatrician versus Lorry at 2 p.m., sustained injury to right upper limb and chest, c/o Shortness of breath. All necessary investigations were done and diagnosed as RIGHT PNEUMOTHORAX, SURGICAL EMPHYSEMA, THROMBOSIS OF BRACHIAL AND BASILIC VEIN, ?? ROTATOR CUFT INJURY, ?? COMPARTMENT SYNDROME. ICD placement was done on 21/03/22 in view of right pneumothorax. Orthopaedic, Neurosurgeon consultations was not taken and advice followed. Patient attendants were explained about the need for further hospital stay, due to affordability issues. Patient is being discharged against medical advice with ICD in situ.

ARH1.0001229336		Name	Mr. ANADAM MYANA	
Patient Identifier	ARHIP55199	Age	66Yr 0Mth 4Days	
Sex	Male	Date of Admission	26-Mar-2022	
Date of Discharge				
MLC No				
Address	Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU13	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

HBSAG+VE

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (29/03/2022) -CAD-DVD (LCX, RCA)

PLAN MEDICAL MANAGEMENT

R/F : HYPERTENSION

C/o chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 66 years old male patient Mr. ANADAM MYANA came with c/o chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, HBSAG+VE, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (29/03/2022) -CAD-DVD (LCX, RCA), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: TELVAS CT ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
6. CAP. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001037
136

Name

Mr. S
JAGA
N
REDD
Y

**Patient
Identifier**

ARHIP55222

Age

39Yr
0Mth
20Days

Sex

Male

**Date of
Admission**

28-
Mar-
2022

**Date of
Discharge
MLC No**

Address

METPALLY,Karimnagar,Andhra Pradesh

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 4

**Primary
Consultant**

DR. SRI KARAN UDDESH

ACUTE PANCREATITIS
KNOWN CASE OF HYPERTENSION
CAD - STATUS POST PTCA

C/o abdominal pain since 1 day

Chronic alcoholic, smoker

KNOWN CASE OF HYPERTENSION
CAD - STATUS POST PTCA

AT ADMISSION:

Patient is conscious

PR: 58/min

BP: 180/100 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Tenderness present on superficial palpation in all regions of the abdomen.

A 39-year-old male patient JAGAN REDDY presented with the above-mentioned complaints. Sr. LIPASE was elevated and CT abdomen revealed features of acute pancreatitis. Patient was started on INJ. TRAMADOL INJ. EMESET and INJ. PAN and TAB. ANTIXIPAN. Patient's clinical condition improved. Patient is now advised further stay in the hospital, but patient's attenders want discharge, hence is being discharged at request.

DISCHARGE MEDICATION:

1. TAB. ULTRACET 1 TAB SOS
2. TAB. ANTOXIPAN ONCE AT 2PM TO CONTINUE
3. TAB. TELMA-H 80/12.5 ONCE AT 8AM TO CONTINUE
4. TAB. MET-XL 25 MG ONCE AT 8AM TO CONTINUE
5. TAB. ECOSPRIN-AV 75/20 MG ONCE AT 8AM TO CONTINUE

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD.

ARH1.0001 168920	Name		Mrs. RAJA MMA VELL APU	
Patient Identifier	ARHIP55153	Age	50Yr 3Mt h 3Da ys	
Sex	Female	Date of Admission	23-Mar-2022	
Date of Discharge MLC No	26-Mar-2022			
Address	CHINTAL THANA, THANGALAPALLY, Karimnagar, Telangana	Ward/Bed No	CIC U , CIC U , Bed no: C ICU4	
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY	Consultants		
Surgeons	Dr. Vidya Sagar A--CARDIOLOGY	Anesthesiologists		

Diagnosis

Disease	Disease Type
---------	--------------

CORONARY ARETERY DISEASE ACUTE ANTEROR WALL MYOCARDIAL INFARCTION
SEVERE LV SYSTOLIC DYSFUNCTION EF-35%
CORONARY ANGIOGRAM DONE ON(25/3/2022)CAD-DVD(LAD AND LCX)
PTCA+DES TO RCA WITH 3V ASTRA 3.0 X 28MM,AND LAD WITH METAFOR 2.75MM X 24MM
DONE ON 25/3/2022.

C/o chest pain since 1 day

AT ADMISSION:

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 50 years old female patient Mrs. RAJAMMA VELLAPU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARETERY DISEASE ACUTE ANTEROR WALL MYOCARDIAL INFARCTION, SEVERE LV SYSTOLIC DYSFUNCTION EF-35%, CORONARY ANGIOGRAM DONE ON(25/3/2022)CAD-DVD(LAD AND LCX), PTCA+DES TO RCA WITH 3V ASTRA 3.0 X 28MM,AND LAD WITH METAFOR 2.75MM X 24MM DONE ON 25/3/2022. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 08.08 AM on 26/03/2022.

CAUSE OF DEATH

CARDIAC ARREST SECONDARY TO CONGESTIVE CARDIAC FAILURE,SEVERE LV DYSFUNCTION,MODERATE MR,SEVERE TR & HOLLOW VISCUS PERFORATION

ARH1.0001157
916

Name

Mrs.
ANDE
VARALAX
MI

**Patient
Identifier**

ARHIP55247

Age

33Yr
8Mth
29Days

Sex

Female

**Date of
Admission**

30-
Mar-
2022

**Date of
Discharge
MLC No**

Address

1-
46,NAGAPUR,MANCHERI
AL
DISTRICT,Luxettipet,Tela
ngana

**Ward/
Bed No**

First
Floor
, Day
Care,
Bed
no:D
C 3

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

ATYPICAL CHEST PAIN
MILD MR, SR
NORMAL LV SYSTOLIC FUNCTION

CORONARY ANGIOGRAM (30/03/2022) - LEFT DOMINANT SYSTEM,
NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o Sudden onset of left sided chest since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 33 years old female patient Mrs. ANDE VARALAXMI came with c/o sudden onset of left sided chest since 1 day. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, MILD MR, SR, NORMAL LV SYSTOLIC FUNCTION, CORONARY ANGIOGRAM (30/03/2022) - LEFT DOMINANT SYSTEM, NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. CAP. ECOSPRIN-AV 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. PROLOMET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
3. CAP. BEVON ONCE DAILY AT 2PM AFTER LUNCH TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001
229394

Name

Mrs.
MUTAMM
A
CHOULA
MADDI

**Patie
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ARHIP55215

Age

50
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Sex

Female

**Date
of
Admi
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28-
Ma
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20
22

**Date
of
Disch
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MLC
No**

**Addr
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H.NO:2-
67,SIRIKONDA,KATHAPUR,JAGITIAL,O
ther,Telangana

**Ward
/Bed
No**

Fir
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Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE AWMI, NO TLT, SR
SEVERE LV SYSTOLIC DYSFUNCTION, EF-35%
S/P CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-DVD
PLAN CABG

C/o chest pain since 1 day

At Admission

Afebrile

PR: 85/min

BP: 100/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 50 years old female patient Mrs. MUTAMMA CHOULAMADDI came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE AWTMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-35%, S/P CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-DVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.000100
5936

Name

Mr.
MUTTOJ
U
VENKA
TA
KISTAIA
H

**Patient
Identifier**

ARHIP55200

Age

58Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

26-
Mar-
2022

**Date of
Discharge
MLC No**

Address

5-7-1155,HOUSING
BOARD
COLONY,Karimnagar,Tela
ngana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR
SEVERE LV SYSTOLIC DYSFUNCTION, EF-35%

S/P KIDNEY TRANSPLANTATION DONE (2008)
CORONARY ANGIOGRAM DONE ON 26/03/2022 - CAD-DVD (LAD RCA)

PRIMARY PTCA+DES TO LAD WITH 2.5 X 20 MM 3V ASTRA DONE ON 26/03/2022

PTCA+DES TO RCA LATER
R/F: HTN,DM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. MUTTOJU VENKATA KISTAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE LATERAL WALL MI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-35%, S/P KIDNEY TRANSPLANTATION DONE (2008), CORONARY ANGIOGRAM DONE ON 26/03/2022 – CAD-DVD (LAD RCA), PRIMARY PTCA+DES TO LAD WITH 2.5 X 20 MM 3V ASTRA DONE ON 26/03/2022, PTCA+DES TO RCA LATER. Nephrologist consultation taken and advice followed. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. IVABRAD 5MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. ALCYSTA TWICE DAILY AT 9AM AND 9PM TO CONTINUE.
- 7) TAB. RECLIDE XR 30 MG ½ TAB ONCE DAILY AT 8AM FOR 5 DAYS.
- 8) CONTINUE TRANSPLANT MEDICATION

REVIEW AFTER 5 DAYS TO CARDIAC OPD & NEPHROLOGY OPD WITH Sr. Urea, Creatinine

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229
404

Name

Mrs.
BHARAT
HI
GUNTI

**Patient
Identifier**

ARHIP55233

Age

48Yr
0Mth
13Days

Sex

Female

**Date of
Admission**

29-
Mar-
2022

**Date of
Discharge
MLC No**

Address

D.NO 15-250 OLD
MNC,Mancherla,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U4

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

VIRAL MYOCARDITIS
DCMP, MILD MR, SR
SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%
R/F: HYPERTENSION, T2 DIABETES MELLITUS, OBESITY

C/o fever since 15 days
Fever subsided 3 days ago
Breathlessness since 3 days

AT ADMISSION:

patient conscious, coherent

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 48 years old female patient Mrs. BHARATHI GUNTI came with c/o fever since 15 days, fever subsided 3 days ago, breathlessness since 3 days. All necessary investigations were done and diagnosed as VIRAL MYOCARDITIS, DCMP, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, R/F: HYPERTENSION, T2 DIABETES MELLITUS, OBESITY. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA

TREATMENT GIVEN:

1.	TAB. ECOSPRIN 150MG	ONCE DAILY	AT 2PM	TO CONTINU E.
2.	TAB. CLOPILET 75 MG	ONCE DAILY	AT 2 P.M.	TO CONTINU E
3.	TAB. ATORVA 40 MG	ONCE DAILY	AT 9 P.M.	TO CONTINU E
4.	TAB. LANOXIN 0.25 MG	ONCE DAILY	AT 8 A.M	TO CONTINU E
5.	TAB. ALDACTON 25 MG	TWICE IN A DAY	AT 8AM & 8PM	TO CONTINU E
6.	TAB. NUCARNIT 500 MG	TWICE IN A DAY	AT 8AM & 8PM	TO CONTINU E
7.	TAB. PAN 40 MG	ONCE DAILY	AT 7 A.M.	FOR 10 DAYS

8	INJ DOBUTAMIN
9	INJ LASIX
1	INJ HUMAN
0	ACTRAPID

ARH1.000
1207629

Name

Mr.
PACHUN
URI
SHANKA
RAIAH

**Patient
Identifier**

ARHIP55204

Age

71Y
r
OMt
h
0Da
ys

Sex

Male

**Date
of
Admission**

27-
Mar-
202
2

**Date
of
Discharge
MLC
No**

Address

MANAKONDUR,KONDAPALKALA,Kari
mnagar,Telangana

**Ward/
Bed
No**

First
Floor,
CIC
U ,
Bed
no:
CIC
U7

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

S/P NEPHRECTOMY DONE ON 2017 AUGUST

CORONARY ANGIOGRAM DONE ON 27/03/2022 - CAD-DVD (LCX, RCA)

PRIMARY PTCA+DES TO RCA WITH 3.0 X 38 MM XIENCE XPEDITION DONE ON
27/03/2022

MEDICAL MANAGEMENT FOR OM

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 89/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 71 years old male patient Mr. PACHUNURI SHANKARAI AH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IOWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P NEPHRECTOMY DONE ON 2017 AUGUST, CORONARY ANGIOGRAM DONE ON 27/03/2022 - CAD-DVD (LCX, RCA), PRIMARY PTCA+DES TO RCA WITH 3.0 X 38 MM XIENCE XPEDITION DONE ON 27/03/2022, MEDICAL MANAGEMENT FOR OM. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. STARPRESS XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS
- 7) TAB. ALCYSTA THRICE IN A DAY AT 8 AM 2 PM 8 PM TO CONTINUE.
- 8) TAB. SOBINIX 500 MG ONCE DAILY AT 8AM TO CONTINUE.

9) TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229
390

**Na
me**

Mr.
KANUKAI
AH
NALLURI .
.

**Patient
Identifier**

ARHIP55212

Age

56Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

28-
Mar-
2022

**Date of
Discharge
MLC No**

Address

H.NO:8-
112/1,GUNDARAM,BEJJANKI,SIDDIPET,Other,Tel
angana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U9

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO RCA (TWO STENTS)WITH 3V ASTRA 3.5 X 12 MM, 3V ASTRA
3.5 X 32 MM DONE ON 28/03/2022
PTCA+DES TO LAD later

C/o SOB on exertion, chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 56 years old male patient Mr. KANUKAIAH NALLURI came with c/o SOB on exertion, chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 28/03/2022 – CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO RCA (TWO STENTS)WITH 3V ASTRA 3.5 X 12 MM, 3V ASTRA 3.5 X 32 MM DONE ON 28/03/2022 PTCA+DES TO LAD later. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001
229395

Name

Mr.
VISHN
U
CHELP
URY ...

**Patie
nt
Identi
fier**

ARHIP55216

Age

47Y
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0Mt
h
3D
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Sex

Male

**Date
of
Admi
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28-
Mar
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202
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**Date
of
Disch
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MLC
No**

**Addr
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PADMANAGAR, KARIMNAGAR, Karimna
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**Ward
/Bed
No**

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Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

R/F: HYPERTENSION, DIABETES MELLITUS, SMOKING, ALCOHOL

CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-DVD (RCA, LAD)

PTCA+DES TO LAD WITH 3.0 X 40 MM METAFOR, RCA WITH 3.5 X 19 MM METAFOR
DONE ON 28/03/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 85/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 47years old male patient Mr. VISHNU CHELPURY came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, R/F: HYPERTENSION, DIABETES MELLITUS, SMOKING, ALCOHOL, CORONARY ANGIOGRAM DONE ON 28/03/2022 – CAD-DVD (RCA, LAD), PTCA+DES TO LAD WITH 3.0 X 40 MM METAFOR, RCA WITH 3.5 X 19 MM METAFOR DONE ON 28/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELISTA 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. OXRAMET XR 1000 MG ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001224
951

**Na
me**

Mr. G
NAGA
RAJU

**Patient
Identifier**

ARHIP55193

Age

58Yr
3Mth
27Da
ys

Sex

Male

**Date of
Admission**

26-
Mar-
2022

**Date of
Discharge
MLC No**

Address

SEETHARAMPUR,KARIMNAGAR,Karimnagar,Tela
ngana

**Ward/
Bed No**

Secon
d
Floor,
Semi
Privat
e,
Bed
no:12
2 A

**Primary
Consultant**

Dr. RAMCHANDER TORREM

ACUTE ON CHRONIC KIDNEY DISEASE
DIABETIC MELLITUS, HYPERTENSION

C/o Shortness of breath, abdominal distention since 2 days

AT ADMISSION:

Afebrile

PR: 72/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. G NAGA RAJU came with c/o shortness of breath, abdominal distention since 2 days. All necessary investigations were done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE, DIABETIC MELLITUS, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. QCEFOR 250MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 2) INJ. INSULATARD 30/70 8 Units **AT 8 AM, 5 Units AT 8 PM** TO CONTINUE.
- 3) TAB. SOBINIX DS TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. DYTOR 40MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. METOZ 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. KETO CHECK THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
- 7) TAB. CUDCE FORTE THRICE DAILY AT 8AM 2PM AND 8PM TO CONTINUE.
- 8) TAB. CARDIVAS 12.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 9) TAB. AZTOLET 40 MG ONCE DAILY AT 9PM TO CONTINUE.
- 10) TAB. ALCYSTA **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 11) TAB. GEROZ-LP THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 12) TAB. CALCI-CZ ONCE IN A DAY AT 8AM TO CONTINUE.
- 13) TAB. MULTI-8 ONCE IN A DAY AT 8AM TO CONTINUE.

REVIEW AFTER 5 DAYS TO NEPHROLOGY OPD

ARH1.000122
9104

Name

Mr.
SATISH
H R

**Patient
Identifier**

ARHIP55208

Age

33Yr
0Mth
10Days

Sex

Male

**Date of
Admission**

27-
Mar-
2022

**Date of
Discharge
MLC No**

Address

KANAGARTHI, ODELA,
PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

Second
Floor
, Semi
Private,
Bed
no:123 C

**Primary
Consultant**

Dr. Iftekarali (MS
(Orthopaedics)

IMPLANT REMOVAL DCP ULNA AND RADIUS

SURGERY : RIGHT IMPLANT REMOVAL DCP ULNA AND RADIUS DONE ON 28/03/2022

Patient came for implant removal

PHYSICAL EXAMINATION:

ON ADMISSION

afebrile

PR-98/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-98%

A 33 years old male patient Mr. SATISH R came for implant removal . All necessary investigations were done and diagnosed as IMPLANT REMOVAL DCP ULNA AND RADIUS, SURGERY : RIGHT IMPLANT REMOVAL DCP ULNA AND RADIUS DONE ON 28/03/2022. Post operative period was uneventful. Now as the

patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

-
1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 2. TAB. SHELCAL 500MG ONCE IN A DAY AT 2PM FOR 11 DAYS
 3. TAB. VOVERAN SR 75MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 4. TAB. RANTAC TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO ORTHO SURGEON OPD.

ARH1.0001
229352

Name

Mrs.
K
NIRM
ALA

Patient Identifier

ARHIP55209

Age

45Yr
0Mth
3Days

Sex

Female

Date of Admission

28-Mar-2022

Date of Discharge MLC No

Address

KATNAPALLI, SULTHANABAD, Karimnagar, Telangana

Ward /Bed No

First Floor
, CICU
, Bed no: CI
CU3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-SVD (LCX)

PRIMARY PTCA+DES TO OM WITH 2.5 X 12 MM 3V ASTRA DONE ON 28/03/2022
R/F: HYPERTENSION

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 140/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 45 years old female patient Mrs. K NIRMALA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 28/03/2022 - CAD-SVD (LCX), PRIMARY PTCA+DES TO OM WITH 2.5 X 12 MM 3V ASTRA DONE ON 28/03/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) LIFE STYLE MODIFICATIONS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001228415

Name

Mr. MIRZA
KHAJA
PASHA
BEG

Patient Identifier

ARHIP55106

Age

54Yr
0Mth
28Days

Sex

Male

Date of Admission

17-Mar-2022

**Date of Discharge
MLC No**

Address

PEDDAPALLI ,Karimnagar,
Telangana

**Ward/
Bed No**

First
Floor,
CT
POST,
Bed
no:CT
3

Primary Consultant

Dr SOMASHEKAR K

CORONARY ARTERY DISEASE + TRIPPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION,
NSTEMI + HYPERTENSION, DIABETES MELLITUS
SURGERY: CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON
26/03/2022.

C/o chest pain a/w SOB since 5 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-99%

A 54 years old male patient Mr. MIRZA KHAJA PASHA BEG presented to hospital with c/o chest pain a/w SOB since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION, NSTEMI + HYPERTENSION, DIABETES MELLITUS, SURGERY: CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 26/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, GLOBAL HYPOKINESIA OF LV, MODERATE LV DYSFUNCTION, MODERATE MR, MILD TR/PAH , NO PE/CLOT/VEG

BMI is 21.1 kg/m².

Sr. Creatinine report on 27.03.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET-A 75+150 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. MET-XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. TRAMADOL 50 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.
- 7) TAB. ROXSAFE CV 500+125 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001217
938

Name

Mr.
MOHM
D
KHASI
M

..

**Patient
Identifier**

ARHIP55109

Age

60Yr
8Mth
5Days

Sex

Male

**Date of
Admission**

17-
Mar-
2022

**Date of
Discharge
MLC No**

Address

DANDEPALLE,Telangana

**Ward/
Bed No**

First
Floor
, CT
POST
, Bed
no:CT
5

**Primary
Consultant**

Dr SOMASHEKAR
K(MS,MCH(CTVS),Consultant-Cardio Thoracic &
Vascular Surgeon)--C T
SURGERY

CORONARY ARTERY DISEASE + TRIPPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION, S/P ANTERIOR WALL MYOCARDIAL INFARCTION, HYPOTHYROIDISM.
SURGERY: CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 25/03/2022.

C/o chest pain a/w SOB since 3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old male patient ^{Mr. MOHMD KHASIM} presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION, S/P ANTERIOR WALL MYOCARDIAL INFARCTION, HYPOTHYROIDISM, SURGERY: CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM, PDA] DONE ON 25/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, MODERATE TR, MILD PAH, TRIVIAL MR NO PE/CLOT/VEG

BMI is 19 kg/m².

Sr. Creatinine report on 26.03.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. THYRONORM 50 MCG ONCE DAILY AT 7AM BEFORE FOOD TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. CORDARONE 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9PM FOR 5 DAYS.
- 8) TAB. DOLO 650 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.
- 9) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

10) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001105332		Name	Mrs. DHOMMATI SATHYALAXMI
Patient Identifier	ARHIP55196	Age	63Yr 10Mth 15Days
Sex	Female	Date of Admission	26-Mar-2022
Date of Discharge MLC No			
Address	BEJJANKI,Karimnagar,Telangana	Ward/Bed No	Second Floor, Semi Private , Bed no:118A
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY		

RIGHT GLUTEAL ABSCESS
SURGERY: RIGHT GLUTEAL ABSCESS I & D DONE ON 29/03/22

Pain and swelling over right gluteal region

Known case of hypothyroidism, hypertension, diabetic mellitus, chronic kidney disease

History of DJ stent, gluteal abscess drainage in 2015

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 63 yrs old female patient Mrs. DHOMMATI SATHYALAXMI came with c/o Pain and swelling over right gluteal region. All necessary investigations done and diagnosed as RIGHT GLUTEAL ABSCESS, SURGERY: RIGHT GLUTEAL ABSCESS I & D DONE ON 29/03/2022. Findings: Large abscess cavity measuring 15 x 10 cm noted in the right upper outer quadrant region of gluteal region. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
1. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 14 DAYS.
2. TAB: DOLO 650 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L **TWICE IN A DAY AT 8 AM 8 PM** FOR 15 DAYS.
5. GLUTAVULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 10 days in General Surgery OPD.

ARH1.00012
29231

Name

Mr.
GANGA
NNA
DASARI

**Patient
Identifier**

ARHIP55190

Age

59Yr
0Mth
7Days

Sex

Male

**Date
of
Admission**

26-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

DHAMMANAPET,JAGITIAL,Other,
Telangana

**Ward/
Bed
No**

Second
Floor,
Female
General
Ward,
Bed
no:GW10

**Primary
Consultant**

Dr. SURESH GOUD S(

LEFT URETERIC CALCULUS
SURGERY: LEFT URSL+DJ STENTING DONE ON 28.03.2022

C/o left loin pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 59 yrs old male patient Mr. GANGANNA DASARI came to the hospital with c/o left loin pain, burning micturition since 7 days. All necessary investigations done and diagnosed as LEFT URETERIC CALCULUS, SURGERY: LEFT URSL+DJ STENTING DONE ON 28.03.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS, STENT REMOVAL AFTER 3 WEEKS

ARH1.000119 0932	Name		Mr. RAJESHA M SALVERI	
Patient Identifier	ARHIP55220	Age	57Yr 1Mth 18Days	
Sex	Male	Date of Admission	28-Mar-2022	
Date of Discharge				
MLC No				
Address	JAGITIAL,Karimnagar,Telangana	Ward/Bed No	Second Floor, Female General Ward, Bed no:GW 8	
Primary Consultant	DR. SANJAY KUMAR KAMINWAR			

ACUTE INFARCT IN RIGHT MCA TERRITORY

C/o sudden weakness of left upper limb and lower limb

History of MVR in 2011, again redo MVR in 2017

K/C/O HTN, T2DM

AT ADMISSION:

Afebrile

PR: 90/min

BP: 150/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 57 years old male patient Mr. RAJESHAM SALVERI came with c/o sudden weakness of left upper limb and lower limb. All necessary investigations were done and diagnosed as ACUTE INFARCT IN RIGHT MCA TERRITORY. Managed conservatively. Patient condition improved

and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB: COLTRO 10MG ONCE DAILY AT 8PM FOR 11DAYS.
2. TAB. PREVA AS 75MG ONCE DAILY AT 2PM FOR 11DAYS.
3. TAB: MET-XL 25MG ONCE DAILY AT 8AM FOR 11DAYS.
4. TAB: GLYCOMET GP1 FORTE ONCE DAILY AT 8AM FOR 11DAYS.

REVIEW AFTER 11 DAYS IN DR. SANJAY KUMAR sir OPD WITH FBS, PLBS REPORTS

ARH1.000122
9290

Name

Mrs.
HAMIR
UNNIS
SA

**Patient
Identifier**

ARHIP55189

Age

39Yr
0Mth
6Days

Sex

Female

**Date
of
Admission**

26-
Mar-
2022

**Date of
Discharge
MLC
No**

Address

SUBASHNAGAR,Karimnagar,Telangana

**Ward/
Bed No**

Second
Floor
,
Female
General
Ward,
Bed
no:GW 5

**Primary
Consultant**

DR. SANJAY KUMAR
KAMINWAR(MD)

ACUTE INFARCT IN RIGHT MCA TERRITORY

C/o sudden weakness of left upper limb and lower limb since 10 days
History of slurring of speech

K/C/O HTN, T2DM

AT ADMISSION:

Afebrile

PR: 97/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 39 years old female patient Mrs. HAMIR UNNISSA came with c/o sudden weakness of left upper limb and lower limb since 10 days, history of slurring of speech. All necessary investigations were done and diagnosed as ACUTE INFARCT IN RIGHT MCA TERRITORY.

Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. PREVA AS 75 MG ONCE DAILY AT 2PM FOR 11DAYS.
2. TAB: VENPRESS 40/12.5 MG ONCE DAILY AT 8AM FOR 11DAYS.
3. TAB: GLYCOMET 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 11DAYS.
4. TAB: COLTRO 10 MG ONCE DAILY AT 8PM FOR 11DAYS.

REVIEW AFTER 11 DAYS IN DR. SANJAY KUMAR sir OPD WITH FBS, PLBS REPORTS.

ARH1.00012
29303

**Na
me**

Mr.
VENKATES
HAM
TOUTU

**Patient
Identifier**

ARHIP55195

Age

60Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

26-
Mar-
2022

**Date of
Discharge
MLC No**

Address

H.NO:3-
41/53,MAMIDALAPALLE,VEENAVANKA,KARIMANGA
R,Telangana

**Ward/Bed
No**

Seco
nd
Floor
,
Male
Gen
eral
War
d,
Bed
no:G
W
13

**Primary
Consultant**

DR. SUBRAT KUMAR SOREN

ACUTE INTRAPARENCHYMAL BLEED (20 X 34 X 26 mm) IN RIGHT LENTIFORM
NUCLEUS AND CORONA RADIATA
SYLVIAN SAH, BASAL CISTERN SAH
? RIGHT THROMBOSED MCA ANEURYSM

C/o sudden slurring of speech, weakness of left upper limb and lower limb

PHYSICAL EXAMINATION:

ON ADMISSION

PR-45/min

BP-160/100mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-100%

GCS: E3,V4,M6

PERL, Left side hemisphere

A 60 yrs old male patient Mr. VENKATESHAM TOUTU came with c/o sudden slurring of speech, weakness of left upper limb and lower limb. All necessary investigations done and diagnosed as ACUTE INTRAPARENCHYMAL BLEED (20 X 34 X 26 MM) IN RIGHT LENTIFORM NUCLEUS AND CORONA RADIATA, SYLVIAN SAH, BASAL CISTERN SAH, ? RIGHT THROMBOSED MCA ANEURYSM. Managed conservatively. GCS- E4, V4, M6, PERL, moving all 4 limbs, left weakness improving 4/5, Right 5/5. Now patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ROXSAFE CV 500+125 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
2. TAB. LEVIPIL 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
3. TAB. NIMODIPINE 30 MG ONCE DAILY 6th hrly
4. TAB. NAXDOM 250 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
5. TAB. TOLVAPTAN 15 MG ONCE DAILY AT 8PM FOR 10 DAYS.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO NEUROSURGERY OPD

Patient Details

UHID Patient Identifier	ARH1.0001228954 ARHIP55185	Name	Mr. SUDHARSHAN CH
Sex	Male	Age	67Yr 0Mth 19Days
Date of Discharge		Date of Admission	25-Mar-2022
MLC No			
Address	H.NO:11-7- 118,P.S.NAGAR,SIRICILLA,Other,Telangana	Ward/ Bed No	First Floor, CT POST, Bed no:CT 4
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+
DM+HTN+, S/P AWMi

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, D1, PDA]
DONE ON 30/03/2022.

C/o chest pain a/w SOB since 3 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-99%

A 67 years old male patient Mr. SUDHARSHAN presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + LV DYSFUNCTION+ DM+HTN+S/P AWTI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, D1, PDA] DONE ON 30/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, MILD MR/AR/TR/PAH , NO PE/CLOT/VEG

BMI is 14.3 kg/m².

Sr. Creatinine report on 31.03.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. THYRONORM 25MCG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. CORDARONE 100MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. DOLO 650 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001229
531

Name

Mr.
CIGIRI
NIRMA
L
KUMA
R

**Patient
Identifier**

ARHIP55268

Age

50Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

01-Apr-
2022

**Date of
Discharge
MLC No**

Address

3-1-369,indira
nagar,,Karimnagar,Tela
ngana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

COMPLETE HEART BLOCK
NORMAL LV SYSTOLIC FUNCTION, EF-65%
CORONARY ANGIOGRAM DONE ON 01/04/2022 - MILD-CAD

PLAN MEDICAL MANAGEMENT

TPI DONE ON 01/04/2022
PPI DONE ON 01/04/2022 (BOSTON SCIENTIFIC PROPONENT DDDR)
R/F: DM, HTN

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. CIGIRI NIRMAL KUMAR came with C/o chest pain since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, NORMAL LV SYSTOLIC FUNCTION, EF-65%, CORONARY ANGIOGRAM DONE ON 01/04/2022 – MILD-CAD, PLAN MEDICAL MANAGEMENT, TPI DONE ON 01/04/2022, PPI DONE ON 01/04/2022 (BOSTON SCIENTIFIC PROPONENT DDDR). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. TAZLOC 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 2) TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10 DAYS.
- 3) TAB. DOLO 650MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.
- 4) TAB. AUGMENTIN DUO 625 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS
- 5) T-BACT OINTMENT FOR L/A FOR 5 DAYS
- 6) TAB. GLYCOMET-SR 500 MG ONCE DAILY AFTER BREAKFAST TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012 29251		Name	Mr. VENKAT ESH INDURI	
Patient Identifier	ARHIP55177	Age		45Y r 0M h 10D ays
Sex	Male	Date of Admission		25- Mar- 202 2
Date of Discharge				
MLC No				
Address	H.NO:5- 7,LAXMIPUR,LUXKETIPET,MANCHIRAIL,Othe r,Telangana	Ward/ Bed No		First Floo r, CT POS T, Bed no: CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio			

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + MODERATE LV DYSFUNCTION+ S/P AWTMI

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA, OM] +IABP DONE ON 28/03/2022.

C/o chest pain since 2 days a/w sweatings

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-81/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 45 years old male patient Mr. VENKATESH INDURI presented to hospital with c/o chest pain since 2 days a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + MODERATE LV DYSFUNCTION+ S/P AWMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA, OM] +IABP DONE ON 28/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, MILD MR/AR/TR/PAH , NO PE/CLOT/VEG

BMI is 24.4 kg/m².

Sr. Creatinine report on 29.03.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. MET XL 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. DOXY 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

10) SYP. ASCORYL-LS THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.00012268
93

Name

Mr. MD
YOUSUF

Patient Identifier

ARHIP55188

Age

70Yr
2Mth
14Days

Sex

Male

Date of Admission

25-Mar-2022

**Date of Discharge
MLC No**

Address

MANKAMMATHOTA, Karimnagar, Telangana

**Ward/
Bed No**

First Floor,
MICU,
Bed no: MICU 3

Primary Consultant

DR. NIKHIL GOLI --NEUROLOGY

CHRONIC KIDNEY DISEASE
SEPSIS
RIGHT MCA INFARCT WITH MULTIPLE SMALL PARENCHYMAL BLEED

C/o slurring of speech since 1 day
Weakness of left upper limb and lower limb,
drowsiness+
High grade fever since 7 days

AT ADMISSION:

Afebrile

PR: 104/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 70 years old male patient Mr. MD YOUSUF came with c/o slurring of speech since 1 day, weakness of left upper limb and lower limb, drowsiness+, high grade fever since 7 days. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, SEPSIS, RIGHT MCA INFARCT WITH MULTIPLE SMALL PARENCHYMAL BLEED. Managed conservatively. Nephrologist consultation taken and advice followed. Poor prognosis explained to the patient attendants. Patient refer to higher center for further management.

DISCHARGE MEDICATION:

1. TAB. AZTOR 40 MG ONCE DAILY AT 2PM FOR 7 DAYS
2. TAB. METOZ 5 MG ONCE DAILY AT 8AM FOR 7 DAYS
3. TAB. CILACAR-M 10/50 MG ONCE DAILY AT 2PM FOR 7 DAYS
4. TAB. SOBINIX-DS ONCE DAILY AT 8PM FOR 7 DAYS
5. TAB. MODALERT 100 MG ONCE DAILY AT 8AM FOR 7 DAYS
6. TAB. THYRONORM ONCE DAILY AT 7AM BBF FOR 7 DAYS
7. TAB. CALCI-CZ 0.2 MG ONCE DAILY AT 2PM FOR 7 DAYS
8. TAB. DOLO 650 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 7 DAYS
9. TAB. GEROZ-LP THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN NEUROLOGY OPD

ARH1.0001229
526

Name

Mr.
BAP
U
CH

**Patient
Identifier**

ARHIP55264

Age

53Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

31-
Mar-
2022

**Date of
Discharge
MLC No**

Address

MANCHERIAL,Tandur,Telan
gana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U9

**Primary
Consultant**

Dr. Vidya Sagar A--

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR
NORMAL LV SYSTOLIC FUNCTION [EF-60%]
CORONARY ANGIOGRAM (04/04/2022) -CAD-SVD (LAD)
PLAN MEDICAL MANAGEMENT FOR DIAGONAL (D2)
R/F : HYPERTENSION, ALCOHOL

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old male patient Mr. BAPU CH came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], CORONARY ANGIOGRAM (04/04/2022) -CAD-SVD (LAD), PLAN MEDICAL MANAGEMENT FOR DIAGONAL (D2). Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012294
93

Name

Mr.
RAJIAH
KALAWALA

**Patient
Identifier**

ARHIP55256

Age

69Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

31-Mar-
2022

**Date of
Discharge
MLC No**

Address

5-132
PEDDAKALAWA, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
2

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, INFERIOR WALL MI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 31/03/2022 - CAD-TVD (LAD, LCX, RCA)

PRIMARY PTCA+DES TO OM WITH 3V ASTRA 3.0 X 28 MM DONE ON 31/03/2022
MEDICAL MANAGEMENT FOR PDA (THIN VESSEL)
R/F: HTN, DM, ALCOHOL

C/o sudden retrosternal chest pain, radiating to back since 1 day a/w
sweating, SOB

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 94%

P/A: Soft

A 69 years old male patient Mr. RAJIAH KALAWALA came with c/o sudden retrosternal chest pain, radiating to back since 1 day a/w sweating, SOB. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, INFERIOR WALL MI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 31/03/2022 - CAD-TVD (LAD, LCX, RCA), PRIMARY PTCA+DES TO OM WITH 3V ASTRA 3.0 X 28 MM DONE ON 31/03/2022, MEDICAL MANAGEMENT FOR PDA (THIN VESSEL). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. COLODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. AZTOR 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ALDACTONE 25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. GLIMP M1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001228
885

Name

Mr.
NARSAIA
H
GADAM

**Patient
Identifier**

ARHIP55187

Age

56Yr
0Mth
22Days

Sex

Male

**Date of
Admission**

25-
Mar-
2022

**Date of
Discharge
MLC No**

Address

6-6-28 NULLKARKHANA
GADAM,Karimnagar,Tela
ngana

**Ward/
Bed No**

First
Floor,
CT
POST
, Bed
no:CT
3

**Primary
Consultant**

Dr SOMASHEKAR K(MS

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV
DYSFUNCTION+ S/P AWTMI+DM+HTN

SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA]
DONE ON 31/03/2022.

C/o chest pain a/w SOB since 7 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-99%

A 56 years old male patient Mr. NARSAIAH GADAM presented to hospital with c/o chest pain a/w SOB since 7 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + SEVERE LV DYSFUNCTION+ S/P AWTMI+DM+HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM, PDA] DONE ON 31/03/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV DYSFUNCTION, MILD MR, NO PE/CLOT/VEG

BMI is 25.8 kg/m².

Sr. Creatinine report on 01.04.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. GLIMIACE-M1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. DOLO 650 MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001229507		Name	Mrs. THAHERA BEGUM
Patient Identifier	ARHIP55270	Age	58Yr 0Mth 5Days
Sex	Female	Date of Admission	01-Apr-2022
Date of Discharge			
MLC No			
Address	korutla,Karimnagar,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. Vidya Sagar A--		

CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION

MILD LV DYSFUNCTION [EF-50%]

R/F : DM, HYPOTHYROID

CORONARY ANGIOGRAM (04/04/2022) -CAD-SVD (Recanalized LAD)

PLAN MEDICAL MANAGEMENT

C/o chest pain since 5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 90%

P/A: Soft

A 58 years old female patient Mrs. THAHERA BEGUM came with c/o chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERIOR WALL MYOCARDIAL INFARCTION, MILD LV DYSFUNCTION [EF-50%], CORONARY ANGIOGRAM (04/04/2022) -CAD-SVD (Recanalized LAD), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. STARPRESS XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. ELTROXIN 50 MCG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. GLYCOMET GP1 ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012
29529

Name

Mr.
MATHAN
GI
SHIVAKU
MAR

**Patient
Identifier**

ARHIP55267

Age

32Yr
0Mth
5Days

Sex

Male

**Date
of
Admission**

31-
Mar-
2022

**Date
of
Discharge
MLC
No**

Address

MANDAMARRI, MANCHERIAL, T
elangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no: CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE ANTERO LATERAL WALL MI

MODERATE LV DYSFUNCTION [EF-45%]

CORONARY ANGIOGRAM (04/04/2022) -LM+DVD (LAD, LCX) Left dominant
system

PLAN : CABG

R/F : DENOVO DIABETES

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 32 years old male patient Mr. MATHANGI SHIVAKUMAR came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE ANTERO LATERAL WALL MI, MODERATE LV DYSFUNCTION [EF-45%], CORONARY ANGIOGRAM (04/04/2022) -LM+DVD (LAD, LCX)Left dominant system, PLAN : CABG . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

54666

ARH1.0001227419		Name	Mrs. SATAYMMA AKULA
Patient Identifier	ARHIP54666	Age	58Yr 0Mth 14Days
Sex	Female	Date of Admission	08-Feb-2022
Expired Date	18-Feb-2022		

IT PROBLEM

CORONARY ARTERY DISEASE, ANTERIO LATERAL MI
SEVERE LV DYSFUNCTION [EF-30%]
PLAN MEDICAL MANAGEMENT

C/o sudden onset of chest pain, radiating to left arm

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 101/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old female patient **Mrs. LAXMI BOMMIDI** came with c/o sudden onset of chest pain, radiating to left arm. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIO LATERAL MI, SEVERE LV DYSFUNCTION [EF-30%], High risk explained to the patient attendants, patient attendants are not willing for CAG. Hence patient is getting discharged with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229
558

Name

Mr.
GATTAIA
H
PULIPAK
A

**Patient
Identifier**

ARHIP55278

Age

76Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

02-
Apr-
2022

**Date of
Discharge
MLC No**

Address

63-
185, Mancheri, Telan
gana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 10

**Primary
Consultant**

DR. NIKHIL GOLI --
NEUROLOGY

POSTERIOR CIRCULATION STROKE
CORONARY ARTERY DISEASE

C/o sudden onset of right upper limb, lower limb weakness since 4 days

History of tingling sensation in right upper limb
Slurring of speech and deviation of angle of mouth
Fever since 2 days
Mild shortness of breath on exertion

AT ADMISSION:

Afebrile

PR: 92/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 76 years old male patient Mr. GATTIAIAH PULIPAKA came with c/o sudden onset of right upper limb, lower limb weakness since 4 days, history of tingling sensation in right upper limb, slurring of speech and deviation of angle of mouth, fever since 2 days, mild shortness of breath on exertion. All necessary investigations were done and diagnosed as POSTERIOR CIRCULATION STROKE, CORONARY ARTERY DISEASE, PLAN CAG. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE IN A DAY AT 2PM TO CONTINUE
2. TAB. CLOPITAB 75 MG ONCE IN A DAY AT 2PM TO CONTINUE
3. TAB. ATORVA 40 MG ONCE IN A DAY AT 8PM TO CONTINUE
4. TAB. ENALAPRIL 5 MG ONCE IN A DAY AT 8AM TO CONTINUE

REVIEW AFTER 7 DAYS IN NEUROLOGY OPD

ARH1.0001229
209

Name

Mr.
POCHAIA
H
VANKAYA
LA

**Patient
Identifier**

ARHIP55181

Age

69Yr
0Mth
14Days

Sex

Male

**Date of
Admission**

25-
Mar-
2022

**Date of
Discharge
MLC No**

Address

RUDRARAM,Sircilla,Telangana

**Ward/
Bed No**

First
Floor
, CT
POST
, Bed
no:CT
4

**Primary
Consultant**

Dr SOMASHEKAR
K(MS,MCH(

CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+SEVERE MITRAL REGURGITATION
SURGERY: CORONARY ARTERY BYPASS GRAFTING (SVG TO PDA+OM) + MVR WITH SJ NO 25MM
MECHANICAL VALVE DONE ON 01/04/2022.

C/o shortness of breath, chest pain since 3 days.

AT ADMISSION

Pt conscious, coherent.

Afebrile

PR: 82/min

BP: 110/70mmHg

RR-18/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 69 years old male patient Mr. POCHIAH VANKAYALA came with c/o shortness of breath, chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+DOUBLE VESSEL DISEASE+SEVERE MITRAL REGURGITATION, SURGERY: CORONARY ARTERY BYPASS GRAFTING (SVG TO PDA+OM) + MVR WITH SJ NO 25MM MECHANICAL VALVE DONE ON 01/04/2022. Post operative period was uneventful. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

POST CABG+MVR 2D ECHO REPORTS SHOWED, PROSTHETIC VALVE INSITU, SEVERE TR/PAH, MILD MR/AR, NO PE/CLOT/VEG

BMI is 25.8 kg/m².

Sr. Creatinine report on 02/04/2022 0.8 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A [75+150] MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CORDARONE 100 MG THRICE DAILY AT 8AM, 2PM AND 8PM TO CONTINUE.
- 3) TAB. ACITROM 1MG AND 2MG 1TAB ALTERNATE DAY AT 7PM TO CONTINUE LIFE LONG
- 4) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ROZAVEL 20 MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. DERIPHYLLINE R 150 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
- 7) TAB. PREDNOSOLONE 5 MG ONCE DAILY AT 2PM FOR 5 DAYS
- 8) TAB. ND-VIT ONCE DAILY AT 2PM TO CONTINUE.
- 9) TAB. MET-XL 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
- 10) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.

11) TAB. DOLO 650MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.

12) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.

13) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT INR REPORT.

ARH1.000122
9672

Name

Mr. J
KOMURAI
AH

**Patient
Identifier**

ARHIP55312

Age

60Yr
0Mth
2Days

Sex

Male

**Date of
Admission**

06-
Apr-
2022

**Date of
Discharge
MLC No**

Address

HANUMAN
NAGAR
KARIMNAGAR ,Ka
ravnagar,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CIC
U4

**Primary
Consultant**

Dr. Vidya Sagar
A--CARDIOLOGY

AV WITH FVR TO SR

NORMAL LV SYSTOLIC FUNCTION

CORONARY ANGIOGRAM (06/04/2022) -NORMAL CORONARIES

ADV: MEDICAL MANAGEMENT

H/o: Etiology HYPERTHYROIDISM

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 60 years old male patient Mr. J KOMURIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as AV WITH FVR TO SR, NORMAL LV SYSTOLIC FUNCTION, CORONARY ANGIOGRAM (06/04/2022) -NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT, h/o: Etiology HYPERTHYROIDISM. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. INDERAL LA 40 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
2. TAB. ACITROM 1 MG ONCE DAILY AT 4PM TO CONTINUE.
3. REFER TO ENDOCRINOLOGIST

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH PT-INR REPORT

ARHIP55275

Mrs. LAXMI BOMMIDI | Female | 52Yr 0Mth 5Days

CORONARY ARTERY DISEASE, ANTERIO LATERAL MI

SEVERE LV DYSFUNCTION [EF-30%]

CORONARY ANGIOGRAM DONE ON 05/4/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 2.75 X 32 MM 3V ASTRA DONE ON 05/04/2022
CARDIOGENIC SHOCK ON INOTROPIC SUPPORT

C/o sudden onset of chest pain, radiating to left arm

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 101/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 52 years old female patient Mrs. LAXMI BOMMIDI came with c/o sudden onset of chest pain, radiating to left arm. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIO LATERAL MI, SEVERE LV DYSFUNCTION [EF-30%], CORONARY ANGIOGRAM DONE ON 05/4/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 2.75 X 32 MM 3V ASTRA DONE ON 05/04/2022, CARDIOGENIC SHOCK ON INOTROPIC SUPPORT. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG ONCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229
553

Name

Mrs.
MANEMM
A UPPU

**Patient
Identifier**

ARHIP55272

Age

69Yr
0Mth
6Days

Sex

Female

**Date of
Admission**

01-
Apr-
2022

**Date of
Discharge
MLC No**

Address

2-5-77 PURANI
PET, Karimnagar, Telan
gana

**Ward/
Bed No**

Second
Floor,
Female
General
Ward,
Bed
no:G
W 2

**Primary
Consultant**

DR. SANJAY KUMAR
KAMINWAR

ACUTE INFARCT IN POSTERIOR CIRCULATION

Patient is in unresponsive state since 2 days
History of fever since 4 days
History of vertigo since 5 days

Known case of diabetes mellitus and hypertension

AT ADMISSION:

Afebrile

PR: 96/min

BP: 150/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft,

A 69 years old female patient Mrs. MANEMMA UPPU came with c/o unresponsive state since 2 days, history of fever since 4 days, vertigo since 5 days. Known case of diabetes mellitus and hypertension. All necessary investigations were done and diagnosed as ACUTE INFARCT IN POSTERIOR CIRCULATION. Managed conservatively. Patient is being

discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: PREVA AS 75MG ONCE DAILY AT 2PM FOR 11DAYS.
2. TAB: ATOCOR 40MG ONCE DAILY AT 8PM FOR 11DAYS.
3. TAB: MODALERT 100MG ONCE DAILY AT 8AM FOR 10DAYS.
4. TAB: TAXIM-O 200MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS.
5. TAB: DOLO 650MG TWICE DAILY AT 8AM 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS IN DR. SANJAYKUMAR sir OPD.

ARH1.0001002
987

Name

Mrs.
RADAVV
A
RAPELLI

**Patient
Identifier**

ARHIP55279

Age

61Yr
1Mth
15Days

Sex

Female

**Date of
Admission**

03-
Apr-
2022

**Date of
Discharge
MLC No**

Address

3-7-42,
SHANTHINAGAR,
SIRCILLA,Karimnagar,Andhra Pradesh

**Ward/
Bed No**

Second
Floor,
Female
General
Ward,
Bed
no:GW 6

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

COMPLETE HEART BLOCK
MILD LV SYSTOLIC DYSFUNCTION, EF-55%
S/P PPI DONE ON 2011

R/F HYPERTENSION

CORONARY ANGIOGRAM DONE ON 07/04/2022 – CAD-DVD (LAD, RCA)

PLAN- PTCA+DES TO LAD, RCA
FLUROSCOPY REVEALS PACEMAKER LOOP IN RV

C/o severe giddiness since 2 days

K/c/o HTN & CAD-CHB

AT ADMISSION:

Afebrile

PR: 37/min

BP: 140/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 61 years old female patient Mrs. RADAVVA RAPELLI came with c/o severe giddiness since 2 days. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK, MILD LV SYSTOLIC DYSFUNCTION, EF-55%, S/P PPI DONE ON 2011, R/F HYPERTENSION, CORONARY ANGIOGRAM DONE ON 07/04/2022 – CAD-DVD (LAD, RCA), PLAN-PTCA+DES TO LAD, RCA, FLUOROSCOPY REVEALS PACEMAKER LOOP IN RV. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. DERIPHYLLIN RETARD 150MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 2) TAB. TONACT 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. CARDACE 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001103
303

**Na
me**

Mr. DEVA
RAJAM

**Patient
Identifier**

ARHIP55265

Age

40Yr
11Mth
23Days

Sex

Male

**Date of
Admission**

31-Mar-
2022

**Date of
Discharge
MLC No**

Address

KHANAPUR,DILAVARPUR,Adilabad(Adilabad),Te
langana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
13

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE-NON STEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 04/04/2022 - CAD-SVD (LAD) D2

PRIMARY PTCA TO LAD & D1 TWO STENTS WITH METAFOR 3.0 X 29 MM, D1 WITH 3V
ASTRA 2.5 X 12 MM DONE ON 04/04/2022
R/F: SMOKER

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 40 years old male patient Mr. DEVA RAJAM came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-NON STEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 04/04/2022 – CAD-SVD (LAD) D2, PRIMARY PTCA TO LAD & D1 TWO STENTS WITH METAFOR 3.0 X 29 MM, D1 WITH 3V ASTRA 2.5 X 12 MM DONE ON 04/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. NEBISTAR 5MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012297
30

Name

Mr. S
VENKATI

**Patient
Identifier**

ARHIP55323

Sex

Male

**Date of
Discharge
MLC No**

**Age
Date of
Admission**

65Yr 0Mth
0Days

07-Apr-
2022

Address

SRIRAMPUR, T
elangana

**Ward/
Bed No**

Ground
Floor,
Emergency Ward,
Bed
no:EME6

**Primary
Consultant**

Dr. Vidya
Sagar A--
CARDIOLOGY

ACUTE PULMONARY OEDEMA IN LVF

C/o Shortness of breath grade 3to 4 since 4 days

Known case of coronary artery disease
S/P CABG, CRHD S/P MVR in 2021
PBMV in 2010, 2015

AT ADMISSION:

Afebrile

PR: 110/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 55-year-old male patient VENKATI presented to the Emergency with shortness of breath grade 3 to 4 since 4 days. All necessary investigations were done and diagnosed as ACUTE PULMONARY OEDEMA IN LVF. Patient was given diuretics, Cardiac contractility drugs. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA

ARH1.00 0120633 5	Name		Mr. PAN DUG A LAX MAN	
	Pati ent Iden tifie r	ARHIP55246	Age	59 Yr 0M th 26 Da ys
	Sex	Male	Date of Admissi on	30- Ma r- 20 22
	Dat e of Disc harg e MLC No	06-Apr-2022		
	Add ress	ramnagar,Karimn agar,Telangana	Ward/ Bed No	Fir st Flo or, MI CU , Be d no: MI CU 4
	Prim ary Con sult ant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))-- INTERNAL MEDICINE	Consulta nts	
	Sur		Anesthe	

geons

siologists

Diagnosis



Diagnosis

Disease	Disease Type

MODS,DM,HTN
UROSEPSIS
METABOLIC ENCEPHALOPATHY

C/o fever since 1 day, SOB

Low urine output since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 140/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Treated with

Inj.Doxybuzz

Inj.Decadron

Inj.Meriverge

Inj.Lasix

Inj.Fluconazole

Inj.PCM

Tab septran-DS

Tab Ursocol

A 59 years old male patient Mr. PANDUGA LAXMAN came with c/o fever since 1 day, SOB, low urine output since 2 days. All necessary investigations were done and diagnosed as MODS,DM,HTN, UROSEPSIS, METABOLIC ENCEPHALOPATHY. Managed conservatively. Nuerosurgeon, Urologist and Nephrologist consultations taken and advice followed, 3 sessions dialysis was done. Patient condition and need for further hospitalization explained to patient attendants, but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001221
655

Name

Mr.
KANIKARAP
U KIRAN
KUMAR ..

**Patient
Identifier**

ARHIP55296

Age

36Yr
4Mth
3Days

Sex

Male

**Date of
Admission**

05-
Apr-
2022

**Date of
Discharge
MLC No**

Address

ponkal
village,Jannaram,Tela
ngana

**Ward/
Bed No**

Seco
nd
Floor,
Semi
Private,
Bed
no:10
6 A

**Primary
Consultant**

Dr Chandra Shekar
Sathineni

ACUTE FEBRILE ILLNESS WITH THROMBOCYTOPENIA

c/o fever associated with altered sensorium since 3 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 36 years old male patient Mr. KANIKARAPU KIRAN KUMAR came with c/o fever associated with altered sensorium since 3 days. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS WITH THROMBOCYTOPENIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
1. TAB. DOXT TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
 2. TAB. MAXBENEFIT ONCE DAILY AT 2PM FOR 5 DAYS
 3. MONITOR VITALS & TEMPERATURE
 4. TAB. VALCIVIR 1 GM THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS
 5. TAB. HYRAX 25 MG ONCE DAILY AT 8PM FOR 5 DAYS
 6. FUDIC CREAM L/A TWICE DAILY AT 8AM AND 8PM
 7. MOIZ IMF LOTION L/A TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.00010 63071		Name	Mr. NARAYAN A GARREPA LLI	
Patient Identifier	ARHIP55292		Age	55Yr 7Mth 29Days
Sex	Male		Date of Admission	04-Apr-2022
Date of Discharge				
MLC No				
Address	3- 149/1,SUNDILLA,KAMANPUR,Karimnagar,Andhra Pradesh	Ward/Bed No	First Floor, CICU , Bed no:CI CU1	

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultant
s**

Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

**Anesthesio
logists**



Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
---------	--------------

CORANARY ARTERY DISEASE,NON ST ELEVATED MYOCARDIAL INFRACTION,SR
SEVER LV SYSTOLIC DYSFUNCTION (EF-30%)
R/F:HYPERTENSION
CORANARY ANGIOGRAM DONE ON (05/04/2022) CAD-TVD(LAD,LCX,RCA)
PLAN:CABG.

C/o chest pain since 1 day

At Admission

Afebrile

PR: 86/min

BP: 100/60 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 55 years old male patient Mr. NARAYANA GARREPALLI came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORANARY ARTERY DISEASE,NON ST ELEVATED MYOCARDIAL INFRACTION,SR, SEVER LV SYSTOLIC DYSFUNCTION (EF-30%), R/F:HYPERTENSION, CORANARY ANGIOGRAM DONE ON (05/04/2022) CAD-TVD(LAD,LCX,RCA), PLAN:CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. GLYCOMET 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

ARH1.000120
2753

Name

Mr.
NARAYA
NA N

Patient
Identifier

ARHIP55178

Age

59Yr
3Mth
9Days

Sex

Male

Date of
Admission

25-
Mar-
2022

Date of
Discharge
MLC No

02-Apr-2022

Address

chakunta,Karimnagar,Tel
angana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MI
CU 9

Primary
Consultant
Surgeons

Dr Chandra Shekar
Sathineni(MD (Internal
Medicine))--INTERNAL
MEDICINE

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
.	

ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE

C/o shortness of breath since 7 days
productive cough, fever since 4 days

H/o old TB [2003], Old CVA [2015]

AT ADMISSION:

Afebrile

PR: 102/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old male patient NARAYANA came with c/o shortness of breath since 7 days, productive cough, fever since 4 days. All necessary investigations were done and diagnosed as ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1) TAB. FAROALFA CV TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

2) TAB. LINOZEN 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

3) TAB. RAZO-L ONCE DAILY AT 7AM BBF FOR 5 DAYS

4) TAB. PIDOTIMMUNE 800 MG ONCE DAILY AT 2PM FOR 5 DAYS

5) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

6) TAB. BILAHENZ-M ONCE DAILY AT 2PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001229665		Name	Mrs. P BAYAMMA	
Patient Identifier	ARHIP55298	Age	79Yr 0Mth 3Days	
Sex	Female	Date of Admission	05- Apr- 2022	
Date of Discharge				
MLC No				
Address	„Karimnagar,Telangana	Ward/Bed No	Second Floor, Semi Private , Bed no:105 B	
Primary Consultant	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE			

COMMUNITY ACQUIRED PNEUMONIA

C/o fever, dyspnoea grade III since 3 days
Cough with expectoration

Known case of bronchial asthma, hypertension and hypothyroid

AT ADMISSION:

Patient is mildly tachypnic
Conscious and coherent
PR: 96/min
BP: 110/80mmHg
Lungs: Bilateral left lower lobe crackles (right >left)
CVS: S1S2
RR: 18/min
SPO2: 88% on room air
P/A: Soft

A 79-year-old female patient BAYAMMA presented with the above-mentioned complaints. Patient was diagnosed to have community acquired pneumonia patient was started on INJ. CEFTAZIDIME and TAZOBACTAM, nebulisation and oxygen at 2 L/min. Over the next 24 hours of hospitalisation patient did not require any oxygen. Patient did not have any fever spikes. Now the patient is symptomatically better and being discharged with following medical advice.

DISCHARGE MEDICATION:

1. TAB. LEVOFLOX 750 ONCE AT 2PM FOR 3 DAYS
2. TAB. PAN 40 MG ONCE AT 7AM BBF FOR 14 DAYS
3. SYP. ASCORYL-D 10 ml THRICE DAILY AT 8AM 2PM 8PM FOR 7 DAYS

4. SEROFLO INHALAR WITH SPACER 250 MG 2 PUFFS TWICE DAILY AT 8AM 8PM
FOR 14 DAYS
5. TAB. THYRONORM 50 MCG ONCE AT 7AM BBF TO CONTINUE

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD.

ARH1.000122
9657

Name

Mr.
KALWA
LA
SARAIA
H

**Patient
Identifier**

ARHIP55303

Age

42Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

05-
Apr-
2022

**Date of
Discharge
MLC No**

Address

PEDDAKALVALA
PEDDAPALLI, Karimnagar, Tel
angana

**Ward/
Bed No**

Seco
nd
Floor
,
Male
Gene
ral
Ward
, Bed
no:G
W 13

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ANTERIOR WALL MI

MODERATE LV DYSFUNCTION [EF-40%]

R/F : HTN, T2DM

CORONARY ANGIOGRAM (07/04/2022) -CAD-Recanalised LAD (mild disease,
OM moderate setnosis)

PLAN MEDICAL MANAGEMENT

C/o chest pain on and off since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient Mr. KALWALA SARAIAH came with c/o chest pain on and off since 1 month. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERIOR WALL MI, MODERATE LV DYSFUNCTION [EF-40%], R/F : HTN, T2DM, CORONARY ANGIOGRAM (07/04/2022) -CAD-Recanalised LAD (mild disease, OM moderate setnosis), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: GLYCOMET-GP1 ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.000122
6619

Name

Mr.
KOMURAI
AH
THANDL
A

**Patient
Identifier**

ARHIP55335

Age

43Yr
2Mth
24Days

Sex

Male

**Date
of
Admission**

08-
Apr-
2022

**Date
of
Discharge
MLC
No**

Address

2-112
SURAIAPALLI, Karimnagar, Telangana

**Ward/
Bed
No**

First
Floor,
Day
Care,
Bed
no:DC1

**Primary
Consultant**

Dr. Iftekarali (MS
(Orthopaedics)

POSTOPERATIVE CASE OF INTERLOCKING NAIL TIBIA RIGHT
SURGERY: DYNAMIZATION OF RIGHT TIBIA DONE ON 08/04/2022

S/P ORIF right tibia+fibula on 17/01/2022

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c
afebrile
PR-86/min
BP-120/70mmhg
RR-24/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 43 years old male patient Mr. KOMURAI AH THANDLA came with postoperative case of interlocking nail tibia right. SURGERY: DYNAMIZATION OF RIGHT TIBIA DONE ON 08/04/2022. Post operative period was uneventful. Now as the patient is

hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
3. TAB. PAN 40 MG ONE DAILY AT 8AM FOR 7 DAYS
4. TAB. SHELCAL 500 MG ONE DAILY AT 2 PM FOR 1 MONTH

REVIEW AFTER 7 DAYS TO ORTHO SURGEON OPD.

ARH1.0001164988

Name

Mr. RAVI
POTU

**Patient
Identifier**

ARHIP55283

Age

54Yr
5Mth
23Days

Sex

Male

**Date of
Admission**

04-Apr-
2022

**Date of
Discharge
MLC No**

Address

DEVAPUR,Karimnagar,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
0

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI

MILD MR, SR

MILD LV DYSFUNCTION, EF-50%

R/F: ALCOHOLIC

CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021

C/o sudden onset of chest pain since 1 day a/w SOB

AT ADMISSION:

Afebrile

PR: 72/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 52years old male patient Mr. GANDLA SHANKARAIHAH came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, MILD MR, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 16/10/2021 - CAD-SVD (LAD), Type-III vessel, proximal LAD significant stenosis. PTCA+DES TO LAD WITH 3.0 X 29 MM METAFOR DONE ON 16/10/2021. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. SARTEL 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229
608

Name

Mrs.
KANTHAV
VA BODA

**Patient
Identifier**

ARHIP55294

Age

84Yr
0Mth
4Days

Sex

Female

**Date of
Admission**

04-
Apr-
2022

**Date of
Discharge
MLC No**

Address

H.NO:3-
75,VEERNAPALLI,RAJAN
NA
SIRICILLA,Other,Telang
ana

**Ward/
Bed No**

Seco
nd
Floor,
Fema
le
Gene
ral
Ward,
Bed
no:G
W 4

**Primary
Consultant**

DR. NIKHIL GOLI --
NEUROLOGY

ACUTE INFARCTS IN RIGHT PCA TERRITORY

C/o weakness of left upper limb and lower limb since 3 days, slurring of speech

AT ADMISSION:

Afebrile

PR: 100/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 97%

P/A: Soft

A 84 years old female patient Mrs. KANTHAVVA BODA came with c/o weakness of left upper limb and lower limb since 3 days, slurring of speech. All necessary investigations were done and diagnosed as ACUTE INFARCTS IN RIGHT PCA TERRITORY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB: ECOSPRIN 150 MG ONCE DAILY AT 2PM FOR 11DAYS.
2. TAB: ATORVA 40 MG ONCE DAILY AT 8PM FOR 11DAYS.

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.000122
9673

Name

Mr.
SHRIKAN
T
LAKKAKU
LA ..

**Patient
Identifier**

ARHIP55304

Age

31Yr
7Mth
4Days

Sex

Male

**Date of
Admission**

05-
Apr-
2022

**Date of
Discharge
MLC No**

Address

1-1-85 NEAR TRITNITY
COLLAGE, Karimnagar, Tel
angana

**Ward/
Bed No**

Seco
nd
Floor
,
Semi
Private,
Bed
no:1
22 A

**Primary
Consultant**

Dr SRINIVAS L--GENERAL
SURGERY

APPENDICULAR MASS ON CONSERVATIVE TREATMENT

C/o pain abdomen since 3 days on and off,
Similar pain since 1 month

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 31 years old male patient Mr. SHRIKANT LAKKAKULA came with c/o pain abdomen since 3 days on and off, similar pain since 1 month. All necessary investigations were done and diagnosed as APPENDICULAR MASS. Managed conservatively. Is the forward clinically some improvement. Patient is referred to higher centre, hence discharged with required medication and advise.

DISCHARGE MEDICATION:

- 1) INJ. ZOSTUM 1.5 GM TWICE DAILY AT 8AM AND 8PM
- 2) INJ. METROGYL 500 MG IV THRICE DAILY AT 8AM, 2PM AND 8PM
- 3) INJ. DYNAPAR-AQ 100 MG TWICE DAILY AT 8AM AND 8PM
- 4) INJ. PAN 40 MG IV ONCE DAILY AT 8AM
- 5) IV fluids NS, RL 100 ml/hr

REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD

ARH1.0001229
400

Name

Mr.
PARSHARAMU
LU
THALLAPALLI

**Patient
Identifier**

ARHIP55229

Age

52Yr
0Mth
11Days

Sex

Male

**Date of
Admission**

29-
Mar-
2022

**Date of
Discharge
MLC No**

Address

H.NO:3-1,KOLIMI
KUNTA,Choppadandi,Tela
ngana

**Ward/
Bed No**

Seco
nd
Floor,
Fema
le
Gene
ral
Ward,
Bed
no:G
W 3

**Primary
Consultant**

DR. SANJAY KUMAR
KAMINWAR(MD)

RIGHT MALIGNANT MCA INFARCT

C/o sudden onset of left upper limb and lower limb weakness
slurring of speech deviation of mouth

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. PARSHARAMULU THALLAPALLI came with c/o sudden onset of left upper limb and lower limb weakness, slurring of speech deviation of mouth. All necessary investigations were done and diagnosed as RIGHT MALIGNANT MCA INFARCT. After 10 days of hospitalisation without inotropic support on O2 8 Ltr/hr, saturation 90-95%, GCS 4/15, Neurosurgeon consultation was also taken and advice followed, very poor

prognosis explained to the patient's attendants and were counselled, patient is being discharged at request .

DISCHARGE MEDICATION:

1. TAB. LEVIPIL 500MG TWICE DAILY AT 8AM AND 8PM FOR 11DAYS.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM FOR 11DAYS.
3. TAB. MODALERT 100MG ONCE DAILY AT 8AM FOR 11DAYS.
4. TAB. COLTRO 10MG ONCE DAILY AT 8PM FOR 11DAYS.

Advice: Air bed, Suctioning regularly & Physiotherapy, RT feeding

REVIEW AFTER 11 DAYS IN DR. SANJAYKUMAR sir OPD.

ARH1.00011649
88

Name

Mr.
RAVI
POT
U

**Patient
Identifier**

ARHIP55283

Age

54Yr
5Mth
23Days

Sex

Male

**Date of
Admission**

04-Apr-
2022

**Date of
Discharge
MLC No**

Address

DEVAPUR,Karimnagar,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
0

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION
NORMAL LV FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 05/04/2022 - CAD-DVD (LAD, RCA, MILD
ISR IN OM)

MEDICAL MANAGEMENT FOR PDA

PTCA+DES TO LAD WITH 3.5 X 20 MM 3V ASTRA DONE ON 05/04/2022

C/o sudden onset of chest pain since 1 day

S/P PTCA TO LCX ON 19/10/2018

AT ADMISSION:

Afebrile

PR: 72/min

BP: 80/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 54 years old male patient Mr. RAVI POTU came with c/o sudden onset of chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON-ST ELEVATION MYOCARDIAL INFARCTION, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 05/04/2022 – CAD-DVD (LAD, RCA, MILD ISR IN OM), MEDICAL MANAGEMENT FOR PDA, PTCA+DES TO LAD WITH 3.5 X 20 MM 3V ASTRA DONE ON 05/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 4) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

APJ1.00017631
61

Name

Mrs.
UPPALAMMA .

Patient Identifier

ARHIP55198

Age

42Yr
10Mth
27Days

Sex

Female

Date of Admission

26-Mar-2022

Expired Date

27-Mar-2022

MLC No

Address

mancheriala,Adilabad(Adilabad),Andhra Pradesh

Ward/Bed No

Ground Floor,
Emergency Ward,
Bed no:EME7

Primary Consultant

Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE

Consultants

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease

Disease Type

SESPSIS.MODS .S/P MVR,AVR

C/o shortness of breath, bilateral pedal edema since 15days, fever and mild cough since 10 days.

AT ADMISSION;

Patient conscious, coherent

PR-100/min

RR-28/min

BP-140/80mmhg

SPO2-98% on o2 15lit

RS-B/L crackles

CVS-s1+,s2+

P/A-soft

A 42 yrs old female patient UPPALAMMA came with c/o shortness of breath, bilateral pedal edema since 15days, fever and mild cough since 10 days. All necessary investigations done and diagnosed as SESPSIS.MODS .S/P MVR,AVR. Patient was on ventilator. On 27/03/2022 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 01.19 PM on 27/03/2022.

CAUSE OF DEATH

SUDDEN CARDIO RESPIRATORY ARREST SECONDARY TO SESPSIS.MODS .S/P MVR,AVR

ARH1.000122 7682	Name	Mr. BHURGU BHUCHAI AH		
Patient Identifier	ARHIP55288	Age		
Sex	Male	64Yr 9Mth 28Days		
Date of Discharge	07-Apr-2022	Date of Admission		
MLC No		04- Apr- 2022		
Address	00-00, PEDDAPUR PEDDAPALLI 9010920200 ,Ju lapalle,Telanga na	Ward/Bed No		
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY	First Floor, CICU , Bed no:CIC U3		
Surgeons	Dr. Vidya Sagar A-- CARDIOLOGY	Consultants		
		Anesthesiologists		
Diagnosis	<div style="text-align: center;"> <input type="checkbox"/> Diagnosis </div>			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Disease</td> <td style="width: 50%; text-align: center;">Disease Type</td> </tr> </table>		Disease	Disease Type
Disease	Disease Type			

CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFRACTION
MILD LV SYSTOLIC DYSFUNCTION EF:30%
RF:HYPERTENSION

CORONARY ANGIOGRAM DONE ON 06/04/2022 CAD-SVD(LAD)
PLAN:CABG WITH GRAFT TO LAD.

C/o sudden onset left sided chest pain

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 64 years old male patient Mr. BHURGU BHUCHAIAH came with c/o sudden onset left sided chest pain. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFRACTION, MILD LV SYSTOLIC DYSFUNCTION EF:30%, RF:HYPERTENSION, CORONARY ANGIOGRAM DONE ON 06/04/2022 CAD-SVD(LAD), PLAN:CABG WITH GRAFT TO LAD. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.

2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NICARDIA-XL 30MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. BETALOC 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001229342		Name	Mr. CH LAXMI NARAYANA	
Patient Identifier	ARHIP55205	Age		60Yr 0Mth 13Days
Sex	Male	Date of Admission		27-Mar-2022
Date of Discharge				
MLC No				
Address	PORANDLA, JAGITYAL,,Karimnagar,Telangana	Ward/Bed No		First Floor, CT POST, Bed no:CT 4
Primary Consultant	Dr SOMASHEKAR K(MS,MCH			

CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWTMI+ HTN

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM] DONE ON 04/04/2022.

C/o chest pain a/w SOB since 3 days

K/c/o HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old male patient Mr. CH LAXMI NARAYANA presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWTMI+ HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM] DONE ON 04/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, PARADOXICAL SEPTAL MOTION, MODERATE LV SYSTOLIC DYSFUNCTION, MILD MR, SEVERE TR, MODERATE PAH , NO PE/CLOT

BMI is __ kg/m².

Sr. Creatinine report on 05.04.2022 1.0 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET-A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. ND-VIT ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. MET XL 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 8) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.
- 9) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.00012296
95

Name

Mr.
DURGA
RAM
PRASA
D V

**Patient
Identifier**

ARHIP55311

Age

48Yr
6Mth
7Days

Sex

Male

**Date of
Admission**

06-Apr-
2022

**Date of
Discharge
MLC No**

Address

12-111/1,
ELAGANDAL, Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
8

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL
INFARCTION

MODERATE LV SYSTOLIC DYSFUNCTION, EF-36%

R/F: DENOVO DIABETES MELLITUS, SMOKER

CORONARY ANGIOGRAM DONE ON 06/04/2022 - CAD-SVD (RCA)

PRIMARY PTCA+DES TO RCA WITH 4.0 X 24 MM METAFOR DONE ON 06/04/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 48 years old male patient Mr. DURGA RAM PRASAD came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION, EF-36%, R/F: DENOVO DIABETES MELLITUS, SMOKER, CORONARY ANGIOGRAM DONE ON 06/04/2022 - CAD-SVD (RCA), PRIMARY PTCA+DES TO RCA WITH 4.0 X 24 MM METAFOR DONE ON 06/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ROSEDAY 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. GLYCOMET GP 0.5 ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. VELOZ 20 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

55313

ARH1.000122
9685

Name	Mr. M RAJU
Patient Identifier	ARHIP55313
Age	39Yr 0Mth 3Days
Sex	Male
Date of Admission	06-Apr-2022
Date of Discharge	
MLC No	
Address	KARIMNAGAR,Karimnagar,Telangana
Ward/Bed No	First Floor, CICU , Bed no:CICU9
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY

CORONARY ARTERY DISEASE, INFERIOR WALL MYOCARDIAL INFARCTION

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

R/F: DIABETES MELLITUS, HYPERTENSION

CORONARY ANGIOGRAM DONE ON 06/04/2022 - CAD-SVD (LCX)

PTCA+DES TO LCX WITH 2.75 X 12 MM 3V ASTRA DONE ON 06/04/2022

C/o chest pain a/w sweating since 1 day

AT ADMISSION:

Afebrile

PR: 102/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 39 years old male patient Mr. M RAJU came with c/o chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, INFERIOR WALL MYOCARDIAL INFARCTION, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, R/F: DIABETES MELLITUS, HYPERTENSION, CORONARY ANGIOGRAM DONE ON 06/04/2022 - CAD-SVD (LCX), PTCA+DES TO LCX WITH 2.75 X 12 MM 3V ASTRA DONE ON 06/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. BETOLOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
- 7) TAB. GLYCOMET GP 0.5 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012
29598

Name

Ms.
MD
SAL
MA

**Patient
Identifier**

ARHIP55320

Age

45Yr
0Mth
5Days

Sex

Female

**Date
of
Admission**

06-
Apr-
2022

**Date
of
Discharge
MLC
No**

Address

SAIDAPUR, HUZURABAD, Karimnagar, Telangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no: CIC
U11

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWM

SEVERE LV DYSFUNCTION, EF-30%

R/F: HTN, DE NOVO DM

CORONARY ANGIOGRAM DONE ON 06/04/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM METAFOR DONE ON 06/04/2022

C/o SOB on exertion, chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 45years old female patient Ms. MD SALMA came with c/o SOB on exertion, chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAWMI, SEVERE LV DYSFUNCTION, EF-30%, R/F: HTN, DENOVO DM, CORONARY ANGIOGRAM DONE ON 06/04/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 16 MM METAFOR DONE ON 06/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROSUVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BISONEXT 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001 158264	Name		Mr. NAR ESH ALV ALA		
Patient Identifier	ARHIP55352	Age	30Yr 9Mth 3Days	Date of Admission	10-Apr-2022
Sex	Male				
Expired Date MLC No	11-Apr-2022				
Address	RAMAKRISHNACOLONY,Karimnagar,Telangana	Ward/Bed No	Ground Floor, Emergency Ward, Bed no:E ME1	Consultants	
Primary Consultant Surgeons	DR. SRI KARAN UDDESH -- INTERNAL MEDICINE	Anesthesiologists			



Diagnosis

S

Diagnosis

Disease	Disease Type
---------	--------------

SEPSIS WITH MULTIPLE ORGAN DYSFUNCTION SYNDROME

C/o loose motions 15-20 episodes
Vomitings 3 episodes
Chronic alcoholic and tobacco chewer
Hyperbilirubinaemia
Known case of CAD, S/P PTCA (2010)

AT ADMISSION:

Patient is conscious and mild respond to deep pain stimulus
PR: 124/min

BP: Not recordable on NORADRENALINE support

CVS: S1S2, tachycardia observed

SPO2: 29% with 100 FIO2

P/A: Soft, BS+

A 30 years old male patient MR. NARESH ALVALA presented with the above-mentioned complaints. Treated with INJ. MEROPENEM INJ. ADRENALIN and INJ. HYDROCORT. Patient condition worsened within hours of hospitalization. So patient was intubated. On 11/04/2022 At 12:00 a.m. patient had a sudden cardiac arrest and CPR was initiated according to ACLS guidelines. Despite best efforts patient could not be revived, hence declared dead at 12.16 a.m. on 11/04/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO SEPSIS WITH MODS , K/C/O CHRONIC LIVER DISEASE, CAD, S/P PTCA (2010)

ARH1.00012
25622

Name

Mr.
THIPPI
RI
CHITTI
SRINI
VAS

**Patient
Identifier**

ARHIP55291

Age

66Yr
3Mth
24Days

Sex

Male

**Date
of
Admission**

04-
Apr-
2022

**Date
of
Discharge
MLC
No**

Address

2-57/1, GARRE
PALLY, PEDDAPALLI, Karimnagar,
Telangana

**Ward/
Bed
No**

First
Floor,
CICU
, Bed
no: CI
CU3

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 18/12/2021 - CAD-SVD (LAD, LCX)

S/P PRIMARY PTCA+DES TO LAD 2STENTS DONE ON 18/12/2021

PRIMARY PTCA+2DES TO LCX, DISTAL LCX WITH BIOFREEDOM 2.75 X 18 mm, MID
LCX BIOFREEDOM 3.0 X 24 mm DONE ON 08/04/2022

R/F: SMOKING

C/o chest pain since few days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 66 years old male patient Mr. THIPPURI CHITTI SRINIVAS came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, **CORONARY ANGIOGRAM DONE ON 18/12/2021 - CAD-SVD (LAD, LCX)**, S/P PRIMARY PTCA+DES TO LAD 2STENTS DONE ON 18/12/2021, PRIMARY PTCA+2DES TO LCX, DISTAL LCX WITH BIOFREEDOM 2.75 X 18 mm, MID LCX BIOFREEDOM 3.0 X 24 mm DONE ON 08/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) TAB. DYTOR PLUS ½ TAB ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122974
1

Name

Mr.
DHANANJAYA
G

**Patient
Identifier**

ARHIP55327

Age

57Yr
6Mth
14Days

Sex

Male

**Date of
Admission**

07-Apr-
2022

**Date of
Discharge
MLC No**

Address

VANINAGAR,JAGITYAL,Telangan
a

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
4

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%

CORONARY ANGIOGRAM DONE ON 08/04/2022 - CAD-SVD (RCA)

PRIMARY PTCA TO RCA 2 STENTS, DISTAL RCA WITH XIENCE XPEDITION 2.75 X 48 mm, MID RCA WITH XIENCE XPEDITION 3.0 X 23 mm DONE ON 08/04/2022

R/F: T2DM, DYSLIPIDEMIA

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 57 years old male patient Mr. DHANANJAYA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, CORONARY ANGIOGRAM DONE ON 08/04/2022 - CAD-SVD (RCA), PRIMARY PTCA TO RCA 2 STENTS, DISTAL RCA WITH XIENCE XPEDITION 2.75 X 48 mm, MID RCA WITH XIENCE XPEDITION 3.0 X 23 mm DONE ON 08/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. STARPRESS XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ZORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. VALOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229740

Name

Mr. PARELLI
LAXMIPATHI

Patient Identifier

ARHIP55331

Age

77Yr
0Mth
4Days

Sex

Male

Date of Admission

07-Apr-2022

**Date of Discharge
MLC No**

Address

8-7-24,
NEHRUNAGAR,Sircilla,Telangana

Ward/Bed No

First Floor,
CICU ,
Bed no:CICU12

Primary Consultant

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE , AWTMI, NO TLT, MILD MR, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

S/P CORONARY ANGIOGRAM DONE ON 09/04/2022 - CAD-TVD [LAD, LCX, RCA]

PLAN CABG.

R/F DM, HTN, SMOKING, ALCOHOL

C/o chest pain a/w sweating since 20 days

At Admission

Afebrile

PR: 80/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 77 years old male patient Mr. PARELLI LAXMIPATHI came with c/o chest pain a/w sweating since 20 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , AWTMI, NO TLT, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%, S/P CORONARY ANGIOGRAM DONE ON 09/04/2022 – CAD-TVD [LAD, LCX, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. TELMA-H 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. TENIVA ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012295
20

Name

Mr. K
RAMESH

**Patient
Identifier**

ARHIP55317

Age

49Yr
0Mth
12Days

Sex

Male

**Date of
Admission**

06-Apr-
2022

**Date of
Discharge
MLC No**

Address

GODAVARIKHANI,Ramagundam,Telang
ana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 1

**Primary
Consultant**

Dr. RAMCHANDER TORREM(MD (

CHRONIC KIDNEY DISEASE, STAGE-V
CORONARY ARTERY DISEASE, UNSTABLE ANGINA
HYPERTENSION, DIABETIC MELLITUS

C/o Swelling of feet, shortness of breath since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 108/min

BP: 190/100mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

Treated with

INJ. CANVICTUS FORTE
INJ. LASIX
TAB. SOBINIX DS
TAB. KETO CHECK
TAB. CUDCE FORTE
TAB. GEROZ LP
TAB. CILACAR M
TAB. MINIPRESS XL
TAB. METOZ
TAB. FEBUGET
TAB. GALIA FORTE
TAB. BIO OMZ 3
INJ. INSUGEN
TAB. SEVLAREN
TAB. VELTAM
TAB. ZINC SHOT
INJ. CARNICRIT
INJ. THYMOX
INJ. PROSTATIN
TAB. ALCYSTA
TAB. ECOSPRIN
TAB. CLOPILET
TAB. TONACT
TAB. PAN
TAB. WYSOLONE

A 49 years old male patient Mr. K RAMESH came with c/o Swelling of feet, shortness of breath since 2 days. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, STAGE-V, CORONARY ARTERY DISEASE, UNSTABLE ANGINA, HYPERTENSION, DIABETIC MELLITUS. Right IJV is placed and haemodialysis is initiated, 4 sessions of haemodialysis done. Cardiologist consultation taken and advised coronary angiogram, but patient attendants are not willing. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA.

ARH1.000122 9762		Na me	Mrs. MOHD ZAIBANIS HA BEGUM
Patient Identifier	ARHIP55339	Age	62Yr 3Mth 4Days
Sex	Female	Date of Admissi on	08-Apr- 2022
Date of Discharge MLC No			
Address	2-8-49/3, KAGAZNAGAR,KOMA RAM BHEEM- 7396960843,Telanga na	Ward/ Bed No	First Floor, CICU , Bed no:CICU 10
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

SEVERE LV SYSTOLIC DYSFUNCTION, EF-30%

CORONARY ANGIOGRAM DONE ON 09/04/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO RCA (TWO STENTS) DISTAL RCA WITH 3.0 X 40 MM 3V
ASTRA, PROXIMAL RCA WITH 3.5 X 24 MM 3V ASTRA DONE ON 09/04/2022

C/o chest pain since 2-3 days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 130/70 mmHg

RS: BAE+

CVS: S1S2

RR: 19/min

SPO2: 98%

P/A: Soft

A 62 years old female patient Mrs. MOHD ZAIBANISHA BEGUM came with c/o chest pain since 2-3 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-30%, CORONARY ANGIOGRAM DONE ON 09/04/2022 - CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO RCA (TWO STENTS) DISTAL RCA WITH 3.0 X 40 MM 3V ASTRA, PROXIMAL RCA WITH 3.5 X 24 MM 3V ASTRA DONE ON 09/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) CAP. ABFLO 100 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 11 DAYS..

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

Devaiah Brain tumor subrat kumar
J laxman 55351 turp sures
Ursl suresh
Laxmidevi tkr vr
Incisional hernia gutham

ARH1.000109705
9

Name

Mr. T
THIRUPATHI

**Patient
Identifier**

ARHIP55359

Age

54Yr 3Mth
3Days

Sex

Male

**Date of
Admission**

11-Apr-
2022

**Date of
Discharge
MLC No**

Address

SALEHNAGAR,
REKURTHI,,Karimnagar,Telanga
na

**Ward/Bed
No**

First Floor,
RECOVERY
ROOM, Bed
no:RR 4

**Primary
Consultant**

Dr. Iftekarali (MS
(Orthopaedics),

IMPLANT TENSION BAND WIRE, SCREW REMOVAL RIGHT
SURGERY : RIGHT IMPLANT TENSION BAND WIRE AND SCREW REMOVAL DONE ON
12/04/2022

Patient came for implant removal

PHYSICAL EXAMINATION:

ON ADMISSION

afebrile

PR-98/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-98%

A 54 years old male patient Mr. T THIRUPATHI came for implant removal . All necessary investigations were done and diagnosed as IMPLANT TENSION BAND WIRE, SCREW REMOVAL RIGHT, SURGERY : RIGHT IMPLANT TENSION BAND WIRE AND SCREW REMOVAL DONE ON 12/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

-
1. TAB. CEFTUM 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 2. TAB. HIFENAC-P TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 3. TAB. RANTAC TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 10 DAYS.
 4. TAB. CALCIMAX ONCE DAILY AT 2 PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO ORTHO SURGEON OPD.

ARH1.0001229768

Name

Mr.
NARESH
KATAKAM

**Patient
Identifier**

ARHIP55342

Age

31Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

09-Apr-
2022

**Date of
Discharge
MLC No**

Address

2-2
BADAMAPLLI, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 3

**Primary
Consultant**

DR. NIKHIL GOLI --NEUROLOGY

ACUTE LEFT MCA INFARCT
CORONARY ARTERY DISEASE
PLAN: CAG

C/o severe headache, mild vertigo since 4 days
Irrelevant speech since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 17/min

SPO2: 100%

P/A: Soft

Treated with

TAB. ECOSPRIN
TAB. AZTOR
INJ. CITICOLON
INJ. MANNITOL
INJ. PARACETAMOL
TAB. MET XL
TAB. CARDACE
TAB. CLOPITAB
TAB. LASIX

A 31 years old male patient Mr. NARESH KATAKAM came with c/o severe headache, mild vertigo since 4 days, irrelevant speech since 1 day. All necessary investigations were done and diagnosed as ACUTE LEFT MCA INFARCT, CORONARY ARTERY DISEASE, PLAN: CAG. Managed conservatively. Cardiologist consultation taken and advised coronary angiogram. Patient attendants requested for discharge, hence patient referred to higher center for further management.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 8 TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. CARDACE 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. DYTOR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. STORVAS 40 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO DR. NIKHIL GOLI SIR OPD

ARH1.000122982
0

**Nam
e**

Mr.
SATTAR
KHAN

**Patient
Identifier**

ARHIP55354

Age

65Yr
0Mth
2Days

Sex

Male

**Date of
Admission**

11-Apr-
2022

**Date of
Discharge
MLC No**

Address

9-2-75/1,
GODAMGADDA, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
2

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR,
SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%]

R/F : T2DM, HYPERTENSION

CVA RIGHT HEMIPLEGIA (24/02/2022)

ACUTE PULMONARY EDEMA RECOVERED

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. SATTAR KHAN came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], R/F : T2DM, HYPERTENSION, CVA RIGHT HEMIPLEGIA (24/02/2022), ACUTE PULMONARY EDEMA RECOVERED. Managed conservatively. Patient was advised CT Scan Brain to rule out intracerebral bleeding, but patient's son was refused for brain imaging. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AX CER 90MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
6. INJ. HUMAN INSULARTED 8 Units AT 8AM, 8 Units AT 8PM BEFORE FOOD TO CONTINUE.
7. INJ. HUMAN ACTRAPID __Units AT 8AM, __Units AT 2PM, __Units AT 8PM S/C TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012
29875

Name

Mr.
MOHAM
MAD
LLIAS

**Patient
Identifier**

ARHIP55370

Age

45Yr
0Mth
0Days

Sex

Male

**Date
of
Admission**

13-
Apr-
2022

**Date
of
Discharge
MLC
No**

Address

H.NO:5-
19,TANDUR,MANCHIRAIL,Other
,Telangana

**Ward/
Bed
No**

Groun
d
Floor,
Emerg
ency
Ward,
Bed
no:EM
E7

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE
ACUTE INFERIOR WALL MYOCARDIAL INFARCTION
MILD LV SYSTOLIC DYSFUNCTION, EF-48%
THROMBOLISATION WITH INJ. RETEPLASE 36 MG DONE ON 12/04/2022 (OUT SIDE)
RISK FACTOR: DENOVO HYPERTENSION, DENOVO DIABETES MELLITUS

C/o Shortness of breath, grade-III since 3 days associated with pain abdomen,
bilateral pedal oedema

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 140/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 90%

P/A: Soft

A 45 years old male patient Mr. MOHAMMAD LLIAS came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE INFERIOR WALL MYOCARDIAL INFARCTION, MILD LV SYSTOLIC DYSFUNCTION, EF-48% , THROMBOLISATION WITH INJ. RETEPLASE 36 MG DONE ON 12/04/2022 (OUT SIDE) , RISK FACTOR: DENOVO HYPERTENSION, DENOVO DIABETES MELLITUS . Managed conservatively. Patient attendants requested for discharge hence patient is being discharged under LAMA.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG **TWICE IN A DAY AT 7 AM 7 PM** FOR 11 DAYS
5. DIABETIC MEDICATION ADVISED BY PHYSICIAN

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00011
08711

Name

Mr.
P
SWA
MY

**Patient
Identifier**

ARHIP55372

Age

55Yr
9Mth
11Days

Sex

Male

**Date
of
Admission**

13-Apr-
2022

**Date
of
Discharge
MLC
No**

Address

KUMMARIPALLY,RAIKAL,Karimnaga
r,Telangana

**Ward/
Bed
No**

First
Floor,
RECOVER
ROOM,
Bed
no:RR
3

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN
TMT POSITIVE
SR, NORMAL LV SYSTOLIC FUNCTION
RISK FACTOR : TYPE-II DIABETIC MELLITUS, HYPERTENSION
CORONARY ANGIOGRAM DONE ON 13/04/2022 - CAD-LAD SLOW FLOW
ADV: MEDICAL MANAGEMENT

C/o chest pain since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. P SWAMY came with c/o chest pain since 1 month. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, TMT POSITIVE , SR, NORMAL LV SYSTOLIC FUNCTION, RISK FACTOR : TYPE-II DIABETIC MELLITUS, HYPERTENSION, CORONARY ANGIOGRAM DONE ON 13/04/2022 - CAD-LAD SLOW FLOW, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. OLMEZEST H 40MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. DILZEM SR 90MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. GLYCOMET GP 0.5 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. NEXPRO 20MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.00012295
29

Name

Mr.
MATHANGI
SHIVAKUMAR

**Patient
Identifier**

ARHIP55307

Age

32Yr
0Mth
13Days

Sex

Male

**Date of
Admission**

06-
Apr-
2022

**Date of
Discharge
MLC No**

Address

MANDAMARRI, MANCHERIAL, Telangana

**Ward/Bed
No**

First
Floor,
CT
POST,
Bed
no:CT
3

**Primary
Consultant**

Dr SOMASHEKAR K(MS,MCH

CORONARY ARTERY DISEASE+LMCA DISEASE + DOUBLE VESSEL DISEASE +
MODERATE LV DYSFUNCTION+ S/P AWMI+ HTN, DENOVO DIABETES
MELLITUS

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO
OM] DONE ON 04/04/2022.

C/o chest pain a/w SOB since 3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-81/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 32 years old male patient Mr. MATHANGI SHIVAKUMAR presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE+LMCA DISEASE + DOUBLE VESSEL DISEASE + MODERATE LV DYSFUNCTION+ S/P AWTMI+ HTN, DE NOVO DIABETES MELLITUS, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM] DONE ON 04/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, MODERATE LV DYSFUNCTION, SEVERE TR/MR, NO PE/CLOT/VEG

BMI is 21 kg/m².

Sr. Creatinine report on 05.04.2022 0.8 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. METFORMIN 500 MG ONCE DAILY AT 7AM BBF TO CONTINUE.
- 5) TAB. ND-VIT ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. PROLOMET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. DIGOXIN 0.25MG ONCE DAILY AT 9AM TO CONTINUE.
- 9) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 10) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 11) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 12) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.00012
29093

Name

Mr.
DAVA
MYSAI
AH

**Patient
Identifier**

ARHIP55137

Age

70Yr
0Mth
6Days

Sex

Male

**Date of
Admission**

21-
Mar-
2022

**Expired Date
MLC
No**

27-Mar-2022

Address

ASIFNAGAR,Karimnagar,T
elangana

**Ward/Bed
No**

Second
Floor,
Male
General
Ward,
Bed
no:GW
23

**Primary
Consultant**

Dr. RAMCHANDER
TORREM(MD (General
Medicine),DM
Nephrology(NIMS),Associate
Consultant-
Nephrologist)--
NEPHROLOGY

Consultants

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
.	

ACUTE ON CHRONIC KIDNEY DISEASE

C/o shortness of breath, bilateral pedal edema since 10days

AT ADMISSION;

Patient conscious, coherent

PR-88/min

BP-130/90mmhg

RR-28/min

RS-BAE+

CVS-s1+,s2+

P/A-soft

SPO2-56% on 10 Lir O2

A 70 yrs old male patient Mr. DAVA MYSIAH came with c/o shortness of breath, bilateral pedal edema since 10days. All necessary investigations done and diagnosed as ACUTE ON CHRONIC KIDNEY DISEASE. On 27/03/2022 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 07.37 PM on 27/03/2022.

CAUSE OF DEATH

SUDDEN CARDIO RESPIRATORY ARREST SECONDARY TO VENTRICULAR
TACHYCARDIA AND CHRONIC KIDNEY DISEASE

ARH1.000122918
0

Name

Mr. G
SAMMAIAH

**Patient
Identifier**

ARHIP55236

Age

55Yr
0Mth
22Days

Sex

Male

**Date of
Admission**

29-
Mar-
2022

**Date of
Discharge
MLC No**

Address

GODAVARIKHANI, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
CT
POST,
Bed
no:CT
4

**Primary
Consultant**

Dr SOMASHEKAR

CHRONIC RHEUMATIC HEART DISEASE, MITRAL
RESTENOSIS+SEVERE TR WITH PAH IN ATRIAL FIBRILLATION+
DIABETES MELLITUS+OBESITY+OLD PULMONARY KOCH'S
SURGERY: MITRAL VALVE REPLACEMENT WITH SJ NO. 27 MM,
MECHANICAL VALVE DONE ON 07/04/2022.

C/o SOB on exertion a/w palpitations since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old male patient ^{Mr. G SAMMAIAH} came with c/o SOB on exertion a/w palpitations since 3 days. All necessary investigations were done and diagnosed as CHRONIC RHEUMATIC HEART DISEASE, MITRAL RESTENOSIS+SEVERE TR WITH PAH IN ATRIAL FIBRILLATION+ DIABETES MELLITUS+OBESITY+OLD PULMONARY KOCH'S, SURGERY: MITRAL VALVE REPLACEMENT WITH SJ NO. 27 MM, MECHANICAL VALVE DONE ON 07/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, she is being discharged with required medication and advice. POST MVR 2D ECHO REPORTS SHOWED PROSTHETIC VALVE INSITU, NORMAL FUNCTIONING PROSTHETIC MV, MILD /TR/PAH , MILD AR, AS. NO PE/CLOT/VEG

BMI is 21.3 kg/m².

Sr. Creatinine report done on 08.04.2022 0.8 mg/dl

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 2MG ONCE DAILY AT 7PM TO CONTINUE LIFE LONG.
- 2) TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. TIGATEL 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 8AM FOR 11 DAYS
- 5) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
- 6) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 7) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS
- 9) USE OWN DIABETIC MEDICATION AS BEFORE

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR, FBS AND PLBS REPORTS

55326 NIRMALA 58

ACUTE DECOMPENSATED HEART FAILURE
AF WITH FVR

CRHD, SEVERE MS, SEVERE TR/MODERATE PAH, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-55%

OBESITY, T2DM

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 58 years old female patient NIRMALA came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, AF WITH FVR, CRHD, SEVERE MS, SEVERE TR/MODERATE PAH, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-55%, OBESITY, T2DM. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. LANOXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE 5/7.
2. TAB. CARDORONE X 200MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
3. TAB. DILZEM 30MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
4. TAB. ACITROM 2MG ONCE DAILY AT 4PM TO CONTINUE.
5. TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS, PT/INR REPORTS

ARH1.0001229
769

Name

Mr. M
NIRANJA
N

**Patient
Identifier**

ARHIP55343

Age

60Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

09-Apr-
2022

**Date of
Discharge
MLC No**

Address

PEDDAPALLI ,Karim
nagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
10

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

PULMONARY THROMBOEMBOLISM
PROGRESSIVE DIABETIC RETINOPATHY
CHRONIC KIDNEY DISEASE
SEVERE LV DYSFUNCTION, SEVERE MR, EF -30%
TYPE-II DIABETES MELLITUS, HYPERTENSION

C/o Shortness of breath grade 2 to 3 since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 101/min

BP: 150/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient ^{Mr. M NIRANJAN} came with c/o Shortness of breath grade 2 to 3 since 3 days. All necessary investigations were done and diagnosed as PULMONARY THROMBOEMBOLISM, PROGRESSIVE DIABETIC RETINOPATHY, CHRONIC KIDNEY DISEASE, SEVERE LV DYSFUNCTION, SEVERE MR, EF -30%, TYPE-II DIABETES MELLITUS, HYPERTENSION. Nephrologist, General Physician and Ophthalmologist consultations taken and advised followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE .
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE .
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 12.5 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. DAPAGYN-M 5/500 MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
7. TAB. CUDCE FORTE TWICE DAILY AT 8AM 8PM TO CONTINUE.
8. TAB. KETO CHECK TWICE DAILY AT 8AM 8PM TO CONTINUE.
9. TAB. ALCYSTA TWICE DAILY AT 8AM 8PM TO CONTINUE.

REVIEW AFTER 5 DAYS TO NEPHROLOGY OPD

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS, RP-II & 2D ECHO REPORTS

55369 MD AHMED 48

INCISIONAL HERNIA

SURGERY : OPEN RETRO-RECTUS MESH REPAIR DONE ON 13/04/2022

C/o epigastric swelling during cough

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c/c

afebrile

PR-75/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 48 yrs old male patient ^{Mr.} MD AHMED came with c/o epigastric swelling during cough. All necessary investigations done and diagnosed as INCISIONAL HERNIA, SURGERY : OPEN RETRO-RECTUS MESH REPAIR DONE ON 13/04/2022. Findings: Large defect involving below the sternum, defect measuring about 7.8 cm. Post operative period was uneventful. Now as

the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ROTAVALT THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPAZ-L TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 10 DAYS.

MONITOR SPO2

DRAIN CARE

Review after 5 days in General Surgery OPD.

ARH1.00012298
02

Name

Mr. T
SATHAIAH

**Patient
Identifier**

ARHIP55349

Age

52Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

10-Apr-
2022

**Date of
Discharge
MLC No**

Address

BATHAKE
PALLI
JAGITIAL ,Telan
gana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

**Primary
Consultant**

Dr. Vidya
Sagar A--
CARDIOLOGY

RIGHT UPPER LIMB PERIPHERAL ARTERIAL DISEASE BRACHIOCEPHALIC ARTERY
COMPLETE OCCLUSION
COPD
NORMAL LV FUNCTION, EF-59%
R/F: HYPERTENSION, DIABETIC MELLITUS, POLYCYTHEMIA VERA
CORONARY ANGIOGRAM (13/04/2022)- CAD MILD DISEASE
PLAN PTA TO RIGHT BRACHIOCEPHALIC ARTERY

C/o Shortness of breath since 7 days
Abdominal discomfort and facial puffiness since 5 days
Fever with cough since 4 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 52 years old male patient Mr. SATHAIAH came with c/o Shortness of breath since 7 days, abdominal discomfort and facial puffiness since 5 days, fever with cough since 4 days. All necessary investigations were done and diagnosed as RIGHT UPPER LIMB PERIPHERAL ARTERIAL DISEASE BRACHIOCEPHALIC ARTERY COMPLETE OCCLUSION, COPD, NORMAL LV FUNCTION, EF-59%, R/F: HYPERTENSION, DIABETIC MELLITUS, POLYCYTHEMIA VERA , CORONARY ANGIOGRAM (13/04/2022)- CAD MILD DISEASE, PLAN PTA TO RIGHT BRACHIOCEPHALIC ARTERY . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
 2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
 3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
 4. CAP. ABFLO 100MG TWICE DAILY AT 8AM 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ADV: CONSULT TO PULMONOLOGIST FOR EVALUATION OF PULMONARY EMBOLISM

ARH1.00012299
35

Name

Mrs. PALLAPU
VANAJA

Patient Identifier

ARHIP55384

Age

28Yr
0Mth
1Days

Sex

Female

Date of Admission

14-Apr-2022

**Expired Date
MLC No**

15-Apr-2022

Address

charlapalli,Karimnagar,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MICU
10

Primary Consultant

Dr Chandra Shekar
Sathineni(MD (Internal
Medicine))--INTERNAL

Consultants

MEDICINE

Surgeons

Diagnosis

S

Anesthesiologists

Diagnosis

Disease	Disease Type
ACUTE RESPIRATORY DISTRESS SYNDROME .	

Alleged history of consumption of **paraquat** pesticide poison around 3 cup full on 13.04.2022 followed by vomiting+

AT ADMISSION:

Patient c/c

PR: 95/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 28 years old female patient Mrs. PALLAPU VANAJA came with alleged history of consumption of **paraquat** pesticide poison around 3 cup full on 13.04.2022 followed by vomiting+. All necessary investigations were done and diagnosed as ACUTE RESPIRATORY DISTRESS SYNDROME. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.31 AM on 15/04/2022.

ARH1.000122998
6

Name

Mrs.
ODEMMA .

Patient Identifier

ARHIP55412

Age

55Yr 0Mth
17Days

Sex

Female

Date of Admission

17-Apr-
2022

**Date of Discharge
MLC No**

Address

2-56, INDIRANAGAR,
KOTHAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

Ground
Floor,
Emergency Ward,
Bed
no:EME2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

R/F : HYPERTENSION

CORONARY ANGIOGRAM (18/04/2022) -LEFT DOMINANT SYSTEM, NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o Profuse sweating a/w palpitations since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old female patient Mrs. ODEMMMA came with c/o profuse sweating a/w palpitations since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV SYSTOLIC FUNCTION [EF-60%], R/F : HYPERTENSION, CORONARY ANGIOGRAM (18/04/2022) -LEFT DOMINANT SYSTEM, NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. VELOZ 20MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.00012 29946	ARHIP5 5397	Mr. THOTL A SRINI VAS Male 32Yr 0Mth 4Days	MI CU 3	15-Apr- 2022		Dr Chan dra Shek ar Sathi neni
---------------------	----------------	--	---------------	-----------------	--	--

SEPSIS
HEPATIC INSUFFICIENCY
RENAL INSUFFICIENCY

C/o severe shortness of breath sudden onset
Pain abdomen
Indigestion
Bilateral pedal oedema

AT ADMISSION:

Afebrile

PR: 102/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 32 years old male patient **Mr. THOTLA SRINIVAS** came with c/o severe shortness of breath sudden onset, Pain abdomen, Indigestion, Bilateral pedal oedema. All necessary investigations were done and diagnosed as SEPSIS, HEPATIC INSUFFICIENCY, RENAL INSUFFICIENCY. Managed conservatively. Patient is now advised further stay in the hospital, but patient's attenders want discharge, hence is being discharged at request.

DISCHARGE MEDICATION:

- 1) TAB. CEFUTIC 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. DOXYLIN 100 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. RAZO-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 4) TAB. URSOCOL 300 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) TAB. RENOSAVE TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 6) TAB. DYTOR PLUS ONCE DAILY AT 8AM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

55414

ARH1.0001229 989	Name		Mr. LING A REDD Y MUSK U	
Patient Identifier	ARHIP55414	Age	49Yr 0Mth 1Day s	
Sex	Male	Date of Admission	18- Apr- 2022	
Date of Discharge MLC No				
Address	1-55 GOLLIPALLI, Karimnagar, Telangana	Ward/ Bed No	Seco nd Floor, Fema le Gene ral Ward , Bed no:G W 9	
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY			

CORONARY ARTERY DISEASE , IWMI, SR, NO TLT
MILD LV SYSTOLIC DYSFUNCTION, EF-45%
S/P OLD CAD [CAG+PTCA (2011)]
S/P CORONARY ANGIOGRAM DONE ON 18/04/2022 - CAD-DVD (LAD, RCA)
PLAN CABG.
R/F T2DM, HTN

C/o Sudden on chest of chest pain associated with shortness of breath, mild sweating since 1 day

At Admission

Afebrile

PR: 90/min

BP: 160/100 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 49 years old male patient Mr. LINGA REDDY MUSKU came with c/o sudden on chest of chest pain associated with shortness of breath, mild sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , IWMI, SR, NO TLT, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, S/P OLD CAD [CAG+PTCA (2011)], S/P CORONARY ANGIOGRAM DONE ON 18/04/2022 – CAD-DVD (LAD, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 80MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. INJ. HUMAN INSULATARD 10 Units S/C TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. INJ. HUMAN ACTRAPID S/C SLIDING SCALE

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.000107209
7

Name

Mr. MOIN
MOHAMMA
D

**Patient
Identifier**

ARHIP55395

Age

67Yr
3Mth
18Days

Sex

Male

**Date of
Admission**

15-Apr-
2022

**Date of
Discharge
MLC No**

Address

2-7-594 MUKURAM PURA
KARIMNAGAR,Karimnagar,Telang
ana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
1

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

ADHF

ANAEMIA (2 PACKED CELL TRANSFUSION+FERRIC CARBOXYMALTOSE 500 MG
INJECTION

CAD, NSTEMI, MILD MR, SR,
SEVERE LV SYSTOLIC DYSFUNCTION (EF 30%)
AF WITH FVR (16/04/2022)

R/F T2DM, HTN

CAD, AWM

CAG+PTCA (01/01/2015) PROXIMAL LAD 100% STENOSIS STENTING TO LAD WITH
BIOMIME 2.75 X 24 mm

C/o SOB and sweating a/w vomitings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 95/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 67 years old male patient Mr. MOIN MOHAMMAD came with c/o SOB and sweating a/w vomitings since 1 day. All necessary investigations were done and diagnosed as ADHF, ANAEMIA (2 PACKED CELL TRANSFUSION+FERRIC CARBOXYMALTOSE 500 MG INJECTION, CAD, NSTEMI, MILD MR, SR, SEVERE LV SYSTOLIC DYSFUNCTION (EF 30%), AF WITH FVR (16/04/2022), R/F T2DM, HTN, CAD, AWTMI, CAG+PTCA (01/01/2015) PROXIMAL LAD 100% STENOSIS STENTING TO LAD WITH BIOMIME 2.75 X 24 mm. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AX CER 90MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDARONE 200 MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
5. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RECLIDE XR 60 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. LIVOGEN ONCE DAILY AT 8AM TO CONTINUE (BEFORE LUNCH).
8. TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.000122
9950

Name

Mr.
NARSAI
AH P

**Patient
Identifier**

ARHIP55400

Age

51Yr
0Mth
4Days

Sex

Male

**Date
of
Admission**

15-Apr-
2022

**Date
of
Discharge
MLC
No**

Address

1-62
PERAPALLY,Karimnagar,Tel
angana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U12

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (18/04/2022) -CAD-Recanalized RCA

PLAN MEDICAL MANAGEMENT

C/o chest pain, radiating to left arm since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 51 years old male patient P. NARSAIAH came with c/o chest pain, radiating to left arm since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (18/04/2022) -CAD- Recanalized RCA, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.00012
29977

Name

Mr.
ELLA
GOUD
BONG
ANI

**Patient
Identifier**

ARHIP55406

Age

51Yr
0Mth
3Days

Sex

Male

**Date
of
Admission**

16-
Apr-
2022

**Date
of
Discharge
MLC
No**

Address

1,
STAMBAMPALLI, RAJANNA, Sircilla,
Telangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no: CIC
U13

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

R/F: DENOVO DM

CORONARY ANGIOGRAM DONE ON 16/04/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD (2 STENTS) MID LAD WITH 3.0 X 24 MM 3V ASTRA,
DISTAL LAD WITH 3.0 X 16 MM 3V ASTRA DONE ON 16/04/2022

C/o chest pain a/w vomiting and sweating

AT ADMISSION:

Afebrile

PR: 75/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 51years old male patient Mr. ELLA GOUD BONGANI came with c/o chest pain a/w vomiting and sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-50%, R/F: DENOVO DM, CORONARY ANGIOGRAM DONE ON 16/04/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD (2 STENTS) MID LAD WITH 3.0 X 24 MM 3V ASTRA, DISTAL LAD WITH 3.0 X 16 MM 3V ASTRA DONE ON 16/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. GLYCOMET SR 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. RAMISTAR H 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.000122997
5

Name

Mrs.
KONKATI
BUCHAMMA

**Patient
Identifier**

ARHIP55405

Age

72Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

16-Apr-
2022

**Date of
Discharge
MLC No**

Address

DESHAIPALLI, Karimnagar, Telangana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no: CICU
8

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV SYSTOLIC FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 16/04/2022 - CAD-Recanalized LAD

PLAN MEDICAL MANAGEMENT

R/F: DENOVO DM

C/o giddiness since 3 days, generalized weakness

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 160/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 72 years old female patient Mrs. KONKATI BUCHAMMA came with c/o giddiness since 3 days, generalized weakness. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV SYSTOLIC FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 16/04/2022 - CAD-Recanalized LAD, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. GLYCOMET SR 250 MG TWICE DAILY AT 8AM AND 8PM AFTER FOOD TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001224
867

Name

Mrs.
LAX
MI
KUN
A

**Patient
Identifier**

ARHIP55429

Age

52Yr
4Mth
18Days

Sex

Female

**Date of
Admission**

19-
Apr-
2022

**Date of
Discharge
MLC No**

Address

4-44
MALKPUR, Karimnagar, Telan
gana

**Ward/
Bed No**

First
Floor,
Day
Care,
Bed
no: D
C 1

**Primary
Consultant**

Dr. SURESH GOUD S(MS,

B/L DJ STENT
SURGERY: B/L DJ STENT REMOVAL DONE ON 19.04.2022

Patient came for DJ stents removal

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 52 yrs old female patient Mrs. LAXMI KUNA came for DJ stents removal. All necessary investigations done and diagnosed as B/L DJ STENT

SURGERY: B/L DJ STENT REMOVAL DONE ON 19.04.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB. QCEFOR 250MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS.
2. TAB. DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. SYP. K-VIT 10 ml TWICE DAILY AT 8AM, 8PM

Review after 10 days to urologist OPD.

ARH1.00010535
36

Name

Mr. MD
AMANULLA
H KHAN

**Patient
Identifier**

ARHIP55379

Age

82Yr
2Mth
9Days

Sex

Male

**Date of
Admission**

13-
Apr-
2022

**Date of
Discharge
MLC No**

Address

7-2-320,
MANKAMMATHOTA,,Karimnagar,And
hra Pradesh

**Ward/Bed
No**

Second
Floor,
Semi
Private
, Bed
no:123
A

**Primary
Consultant**

Dr. Iftekarali (MS
(Orthopaedics),Consultant
Orthopaedic Surgeon)--
ORTHOPAEDICS

ARH1.00010535
36

Name

Mr. MD
AMANULLA
H KHAN

**Patient
Identifier**

ARHIP55379

Age

82Yr
2Mth
9Days

Sex

Male

**Date of
Admission**

13-
Apr-
2022

**Date of
Discharge
MLC No**

Address

7-2-320,
MANKAMMATHOTA,,Karimnagar,And
hra Pradesh

**Ward/Bed
No**

Second
Floor,
Semi
Private
, Bed
no:123
A

**Primary
Consultant**

Dr. Iftekarali (MS
(Orthopaedics),Consultant
Orthopaedic Surgeon)--
ORTHOPAEDICS

INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT

SURGERY : CEMENTED BIPOLAR HEMIARTHOPLASTY LEFT HIP DONE ON 16/04/2022

Alleged to have sustained injury due to slip and fall at home

C/o pain and swelling in left hip.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c
afebrile
PR-80/min
BP-120/80mmhg
RR-24/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 82 years old male patient Mr. MD AMANULLAH KHAN came with alleged history of sustained injury due to slip and fall at home, c/o pain and swelling in left hip. All necessary investigations were done and diagnosed as INTRACAPSULAR FRACTURE NECK OF FEMUR LEFT, SURGERY : CEMENTED BIPOLAR HEMIARTHOPLASTY LEFT HIP DONE ON 16/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION

1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
2. TAB. SHELICAL 500 MG ONCE DAILY AT 2PM FOR 11 DAYS
3. TAB. RANTAC TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.

REVIEW AFTER 11 DAYS TO ORTHOPAEDIC OPD.

ARH1.00012
29981

**Na
m
e**

Mrs.
KALAVA
THI
MADISH
ETTI

**Patient
Identifier**

ARHIP55409

Age

71Yr
0Mth
4Days

Sex

Female

**Date
of
Admis
sion**

16-
Apr-
2022

**Date of
Discharge
MLC No**

Address

H.NO:18-4-
198,MARUTHINAGAR,GODHAVARIKHANI,PEDDAPALLY,
Other,Telangana

**Ward/
Bed
No**

First
Floor,
CICU ,
Bed
no:CIC
U11

**Primary
Consultan
t**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWMi, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-56%

S/P CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-TVD

PLAN CABG.

R/F HTN

C/o Retrosternal chest pain a/w sweating since 1 day

At Admission

Afebrile

PR: 80/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 71 years old female patient Mrs. KALAVATHI MADISHETTI came with c/o retrosternal chest pain a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-56%, S/P CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-TVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001229976

Name

Mr. MD
MUNTAZ
ALI

**Patient
Identifier**

ARHIP55411

Age

65Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

17-
Apr-
2022

**Date of
Discharge
MLC No**

Address

ntpc,
godavariokhani,Karimnagar,Telan
gana

**Ward/
Bed No**

Secon
d
Floor,
Semi
Private
, Bed
no:123
C

**Primary
Consultant**

Dr Chandra Shekar Sathineni

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

C/o shortness of breath on exertion, generalised weakness since 2-3 days

AT ADMISSION:

Afebrile

PR: 83/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96% on room air

P/A: Soft

A 65 years old male patient Mr. MD MUNTAZ ALI came with c/o shortness of breath on exertion, generalised weakness since 2-3 days. All necessary investigations were done and diagnosed as CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. CEFUTIC 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. LINEZOLID 600 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 3) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS
- 4) TAB. BILAHENZ-M ONCE DAILY AT 2PM FOR 30 DAYS
- 5) TAB. PIDOTIMMUNE 400MG TWICE DAILY AT 8AM AND 8PM FOR 30 DAYS
- 6) TAB. NICARDIA RETARD 20 MG ONCE DAILY AT 8AM FOR 30 DAYS
- 7) TAB. ATOCOR CV ONCE DAILY AT 8PM FOR 30 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230024

Name

Mr. MOTAM
KRISHNA

Patient Identifier

ARHIP55423

Age

24Yr
0Mth
2Days

Sex

Male

**Date of
Admission**

18-
Apr-
2022

**Date of Discharge
MLC No**

Address

chainoor,Mancheria,Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:119
B

Primary Consultant

Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General Surgeon)--
GENERAL SURGERY

RIGHT EAR LACERATION WITH SDH

SURGERY: RIGHT EAR LACERATION SUTURING WITH FRONTAL SKIN LACERATION SUTURING DONE ON
19/04/2022

Alleged to have sustained injuries due to slip and fall from bike on 18/04/2022 around 1.30
PM

Sustained injuries to head and all over the body
H/o LOC for 30 min

PHYSICAL EXAMINATION:

ON ADMISSION

Patient c/c/c

afebrile

PR-98/min

BP-120/80mmhg

RR-24/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 24yrs old male patient ^{Mr. MOTAM KRISHNA} came with alleged to have sustained injuries due to slip and fall from bike on 18/04/2022 around 1.30 PM, sustained injuries to head and all over the body, h/o LOC for 30 min. All necessary investigations done and diagnosed as RIGHT EAR LACERATION WITH SDH, SURGERY: RIGHT EAR LACERATION SUTURING WITH FRONTAL SKIN LACERATION SUTURING DONE ON 19/04/2022. Findings: Large laceration involving right ear causing near total displacement of the ear. Laceration involving the frontal region and right chest below the clavicle. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ROTAVAUULT THRICE DAILY AT 8AM, 2PM, 8PM FOR 10 DAYS.
3. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
5. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
6. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
7. T-BACT OINTMENT FOR L/A

Review after 10 days in General Surgery OPD.

ARH1.0001230027

Name

Mr. RAJU
LAVUDIA

Patient Identifier

ARHIP55427

Age

27Yr
10Mth
6Days

Sex

Male

**Date of
Admission**

19-
Apr-
2022

**Date of Discharge
MLC No**

Address

3-+64, KAMMARKHANPET THANDA,
DHARMARAM,
PEDDAPALLY,Karimnagar,Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:119
A

Primary Consultant

DR. NIKHIL GOLI --NEUROLOGY

REFRACTIVE HEADACHE

C/o Severe headache since 1 week
H/o vomitings and nausea+

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 27 years old male patient Mr. RAJU LAVUDIA came with c/o severe headache since 1 week, h/o vomitings and nausea+. All necessary investigations were done and diagnosed as REFRACTIVE HEADACHE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. NAXDOM 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. REXIPRA 5 MG ONCE DAILY AT 8PM FOR 7 DAYS
- 3) MONITOR VITALS

REVIEW AFTER 7 DAYS IN DR. NIKHIL GOLI SIR OPD

ARH1.0001229881

Name

Mr.
SRINIVAS
GANDLA

Patient Identifier

ARHIP55377

Age

50Yr
0Mth
7Days

Sex

Male

**Date of
Admission**

13-Apr-
2022

**Date of Discharge
MLC No**

Address

GOLLAPALLY,Sircilla,Telangana

**Ward/
Bed No**

Second
Floor,
Male
General
Ward,
Bed
no:GW1
6

Primary Consultant

Dr. SURESH GOUD S

RIGHT PROXIMAL URETERIC CALCULUS
SURGERY: RIGHT PUSH BACK PCNL+DJ STENTING DONE ON 16.04.2022

C/o Right loin pain, burning micturition since 5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 50 yrs old male patient Mr. SRINIVAS GANDLA came to the hospital with c/o right loin pain, burning micturition since 5 days. All necessary investigations done and diagnosed as RIGHT PROXIMAL URETERIC CALCULUS, SURGERY: RIGHT PUSH BACK PCNL+DJ STENTING DONE ON 16.04.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

Review after 11 days, stent removal after 3 weeks

ARH1.0001229806

Name

Mr. T ANJANEYULU

Patient Identifier

ARHIP55350

Age

27Yr
0Mth
10Days

Sex

Male

Date of Admission

10-Apr-2022

**Date of Discharge
MLC No**

15-Apr-2022

Address

MANAKONDUR
ANNARAM,Karimnagar,Telangana


Ward/Bed No

Second
Floor,
Semi
Private
, Bed
no:118
B

Primary Consultant
Surgeons

Dr Chandra Shekar Sathineni(MD
(Internal Medicine))--INTERNAL
MEDICINE

Consultants
Anesthesiologists

 **Diagnosis**
S

Diagnosis

Disease	Disease Type
---------	--------------

DIABETIC KETOACIDOSIS
OBSESSIVE COMLULSIVE DISORDER WITH PSYCHOTIC FEATURES

C/o altered sensorium, generalised weakness since 1 day

AT ADMISSION:

Afebrile
PR: 116/min
BP: 80/60mmHg
RS: BAE+
CVS: S1S2
RR: 18/min
SPO2: 100%
P/A: Soft
GCS:E4,V2,M5

A 27 years old male patient Mr. T ANJANEYULU came with c/o altered sensorium, generalised weakness since 1 day. All necessary investigations were done and diagnosed as DIABETIC KETOACIDOSIS , OBSESSIVE COMLULSIVE DISORDER WITH PSYCHOTIC FEATURES. Managed conservatively. Psychiatrist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. SULPITAC 100 MG ONCE DAILY AT 8PM FOR 5 DAYS
- 2) TAB. FLUTOP 20 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. RISCON-LS ½ TAB TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 4) TAB. CLUE BETA 10 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001229905

		Mr. RAJA MOULI GUJJETI	
Patient Identifier	ARHIP55385	Age	68Yr 0Mth 6Days
Sex	Male	Date of Admission	14-Apr-2022
Date of Discharge			
MLC No			
Address	KMR,Karimnagar,Telangana	Ward/ Bed No	Second Floor, Male General Ward, Bed no:GW 13
Primary Consultant	Dr. Iftekarali (MS (Orthopaedics		

INTRACAPSULAR FRACTURE NECK OF FEMUR RIGHT HIP
SURGERY : HEMIORTHOPLASTY WITH AMP RIGHT DONE ON 16/04/2022

Alleged to have sustained injury due to fall from two wheeler
C/o pain and swelling in right hip.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c
afebrile
PR-81/min
BP-110/70mmhg
RR-20/min
RS-BAE+
CVS-S1S2+
P/A-Soft
SPO2-98%

A 68 years old male patient Mr. RAJA MOULI GUJJETI came with alleged to have sustained injury due to fall from two wheeler, c/o pain and swelling in right hip. All necessary investigations were done and diagnosed as

INTRACAPSULAR FRACTURE NECK OF FEMUR RIGHT HIP, SURGERY: HEMIORTHOPLASTY WITH AMP RIGHT DONE ON 16/04/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence she is being discharged with required medication and advice.

DISCHARGE MEDICATION:

-
1. TAB. ROXSAFE CV 500MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.
 2. TAB. RANTAC TWICE DAILY AT 7AM & 7PM (BEFORE FOOD) FOR 11 DAYS.
 3. TAB: METROGYL 400MG THRICE IN A DAY AT 8AM, 2PM, 8PM FOR 7 DAYS
 4. TAB. SHELCAL 500 MG ONCE DAILY AT 2PM FOR 11 DAYS
 5. TAB. VOVERAN SR 75MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS.

REVIEW AFTER 11 DAYS TO ORTHOPAEDIC OPD.

ARH1.0001229684

Name	Mrs. KINNERA LAXMI		
Patient Identifier	ARHIP55394	Age	50Yr 2Mth 14Days
Sex	Female	Date of Admission	15-Apr-2022
Date of Discharge			
MLC No			
Address	3-28, PORANDLA,Karimnagar,Telangana	Ward/ Bed No	Second Floor, Female General Ward, Bed no:GW 5
Primary Consultant	Dr. SURESH GOUD S		

RIGHT RENAL CALCULUS
SURGERY: RIGHT PCNL+DJ STENTING DONE ON 16.04.2022

C/o Right flank pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 50 yrs old female patient Mrs. KINNERA LAXMI came to the hospital with c/o right flank pain, burning micturition since 7 days. All necessary investigations done and diagnosed as RIGHT RENAL CALCULUS, SURGERY: RIGHT PCNL+DJ STENTING DONE ON 16.04.2022. Post operative period was uneventful. Patient symptomatically improved. Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

Review after 11 days, stent removal after 3 weeks

ARH1.0001228266

		Mr. RAMESH SAMUDRALA	
	Patient Identifier	ARHIP55386	Age 38Yr 1Mth 24Days
	Sex	Male	Date of Admission 14-Apr-2022
	Date of Discharge MLC No		
	Address	6-2-466 HUSSAINIPURA, Karimnagar, Telangana	Ward/ Bed No Second Floor, Male General Ward, Bed no: GW 18
	Primary Consultant	Dr. SURESH GOUD S(MS)	

LEFT RENAL CALCULUS
SURGERY: LEFT PCNL+DJ STENTING DONE ON 16.04.2022

C/o left flank pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 38 yrs old male patient Mr. RAMESH SAMUDRALA came to the hospital with c/o left flank pain, burning micturition since 7 days. All necessary investigations done and diagnosed as LEFT RENAL CALCULUS, SURGERY: LEFT PCNL+DJ STENTING DONE ON 16.04.2022. Post operative period was uneventful. Patient symptomatically improved. Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

Review after 11 days, stent removal after 3 weeks

ARH1.0001229940		Name	Mrs. K BHARATHI
Patient Identifier	ARHIP55388	Age	47Yr 0Mth 6Days
Sex	Female	Date of Admission	14-Apr-2022
Date of Discharge	14-Apr-2022		
MLC No			
Address	karimnagar,Karimnagar,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU 1
Primary Consultant Surgeons	Dr. Vidya Sagar A--CARDIOLOGY Dr. Vidya Sagar A--CARDIOLOGY	Consultants Anesthesiologists	

Diagnosis

Diagnosis

S

Diseas

Disease

e	Type
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CORONARY ARTERY DISEASE-STABLE ANGINA,NO TLT
R/F HYPERTENSION,ASTHAMA
CORONARY ANGIOGRAM DONE ON 14/4/2022
IMP:NORMAL CORONARIES
PLAN:PATIENT CAN UNDERGO NON CARDIAC SURGERY UNDER LOW RISK.

C/o SOB on exertion a/w cough since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 99/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 47 years old female patient Mrs. K BHARATHI came with c/o SOB on exertion a/w cough since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-STABLE ANGINA,NO TLT, R/F HYPERTENSION,ASTHAMA, CORONARY ANGIOGRAM DONE ON 14/4/2022, NORMAL CORONARIES, PLAN:PATIENT CAN UNDERGO NON CARDIAC SURGERY UNDER LOW RISK. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1.TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001229854

Name

Mr. RAMULU
SUNCHU

Patient Identifier

ARHIP55361

Age

64Yr 0Mth 8Days

Sex

Male

**Date of
Admission**

11-Apr-2022

Expired Date

19-Apr-2022

MLC No

Address

8-10/1, Kaman
Poor,Other,Telangana

Ward/Bed No

First Floor, SICU,
Bed no:SICU 4

Primary Consultant

Dr. GOUTHAM ROY
(MS(General
Surgery),Consultant General
Surgeon)--GENERAL
SURGERY

Consultants

Surgeons

Dr. GOUTHAM ROY
(MS(General
Surgery),Consultant General
Surgeon)--GENERAL
SURGERY

Anesthesiologists

Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY



Cause of
Death

Cause of Death



Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
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ACUTE INTESTINAL OBSTRUCTION SECONDARY TO CARCINOMA SIGMOID COLON

C/o pain abdomen since 10 days
Constipation, Vomitings and low-grade fever since 20 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-80/min

BP-120/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-90%

A 64 yrs old male patient Mr. RAMULU SUNCHU came with c/o pain abdomen since 10 days. All necessary investigations done and diagnosed as ACUTE INTESTINAL OBSTRUCTION SECONDARY TO CARCINOMA SIGMOID COLON, SURGERY : OPEN SIGMOID COLOSTOMY + LOOP ILEOSTOMY WITH END TO END COLORECTAL ANASTOMOSIS DONE ON 12/04/2022. Patient was on ventilator. On 19/04/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 04.32 PM on 19/04/2022.

CAUSE OF DEATH

ACUTE RESPIRATORY DISTRESS SYNDROME WITH RESPIRATORY FAILURE

APJ1.0001214416

		Name		Mrs. IMMADI LAXMI SUDHA	
Patient Identifier		ARHIP55382		Age	48Yr 0Mth 7Days
Sex		Female		Date of Admission	14-Apr-2022
Date of Discharge MLC No					
Address		SRINIVASA STEEL STORE RAJEEV ROAD P/O CHANNOOR,Adilabad(Adilabad),Telangana		Ward/ Bed No	Second Floor, Semi Private , Bed no:108 A
Primary Consultant		Dr Chandra Shekar Sathineni(MD (Internal			

PULMONARY KOCH'S
DIABETIC MELLITUS
HYPERTENSION
HYPOTHYROIDISM

C/o Cough with expectoration, decreased appetite, loss of weight since 1 month

AT ADMISSION:

Afebrile

PR: 120/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 27/min

SPO2: 95%

P/A: Soft

A 48 years old female patient Mrs. IMMADI LAXMI SUDHA came with c/o cough with expectoration, decreased appetite, loss of weight since 1 month. All necessary investigations were done and diagnosed as PULMONARY KOCH'S, DIABETIC MELLITUS, HYPERTENSION, HYPOTHYROIDISM. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. CEFUTIC 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. GLUCO-Q10 ONCE DAILY AT 8AM FOR 15 DAYS
- 4) TAB. BENADON 40 MG ½ TAB ONCE DAILY AT 8AM FOR 5 DAYS
- 5) TAB. AKT 4 KIT
- 6) INJ. LANTUS 20 U ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. OXRA 10 MG ONCE DAILY AT BEFORE LUNCH TO CONTINUE.
- 8) TAB. TAZOLAC CT ONCE DAILY AT 8AM FOR 5 DAY
- 9) TAB. ARVAST CV ONCE DAILY AT 8PM FOR 5 DAY

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001229892

Name

Mr. V RAJA
MALLAIAH

**Patient
Identifier**

ARHIP55407

Age

83Yr
0Mth
8Days

Sex

Male

**Date of
Admission**

16-
Apr-
2022

**Date of
Discharge
MLC No**

Address

huzurabad,Karimnagar,Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:120
B

**Primary
Consultant**

Dr. SURESH GOUD S

STRICTURE URETHRA
SURGERY: OPTICAL URETHROTOMY DONE ON 18/04/2022

C/o difficulty in passing urine, dribbling of urine
H/o dribbling of urine
K/C/O CVA, DM & HTN

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 83 yrs old male patient Mr. V RAJA MALLAIAH came to the hospital with c/o difficulty in passing urine, dribbling of urine. All necessary investigations done and diagnosed as STRICTURE URETHRA, SURGERY: OPTICAL URETHROTOMY DONE ON 18/04/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO UROLOGY OPD

ARH1.0001230004

Name

Mr. MEKALA
KOMARAI AH

**Patient
Identifier** ARHIP55416

Age 59Yr 3Mth
3Days

Sex Male

**Date of
Admission** 18-Apr-
2022

**Date of
Discharge**

MLC No

Address 1-28,
JALLARAM, PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No** First Floor,
CICU , Bed
no: CICU10

**Primary
Consultant** Dr. Vidya Sagar A--CARDIOLOGY
t

CORONARY ARTERY DISEASE, NSTEMI, SR, NO TLT

NORMAL LV SYSTOLIC FUNCTION [EF-60%]

S/P RENAL CALCULI

CORONARY ANGIOGRAM (20/04/2022) -CAD-LAD mid myocardial bridging

PLAN MEDICAL MANAGEMENT

C/o Shortness of breath associated with palpitations since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 59 years old male patient Mr. MEKALA KOMARAI AH came with c/o shortness of breath associated with palpitations since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, NO TLT, NORMAL LV SYSTOLIC FUNCTION [EF-60%], S/P RENAL CALCULI, CORONARY ANGIOGRAM (20/04/2022) -CAD-LAD mid myocardial bridging, plan medical management . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001229937

Name

Mr.
SRINIVAS
RELLA

Patient Identifier

ARHIP55390

Age

46Yr
0Mth
7Days

Sex

Male

**Date of
Admission**

14-Apr-
2022

**Date of Discharge
MLC No**

Address

GODAVARIKANI,Ramagundam,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 10

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NON ST ELEVATED MI, SR, NO TLT
MODERATE LV DYSFUNCTION, EF-40%, MILD MR
R/F: HTN, T2DM
CORONARY ANGIOGRAM DONE ON 18/04/2022 - CAD-SVD (LAD)
PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR DONE ON 18/04/2022

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. SRINIVAS RELLA came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATED MI, SR, NO TLT, MODERATE LV DYSFUNCTION, EF-40%, MILD MR, R/F: HTN, T2DM, CORONARY ANGIOGRAM DONE ON 18/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 13 MM METAFOR DONE ON 18/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PROLOMET R 25/2.5MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. PROLOMET XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229558

Name

**Mr.
GATTAI
AH
PULIPA
KA**

**Patient
Identifier**

ARHIP55391

Age

46Yr
0Mth
7Days

Sex

Male

**Date of
Admission**

14-Apr-
2022

**Date of
Discharge
MLC No**

Address

63-185,Mancheria,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 9

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NON ST ELEVATED MI, SR, NO TLT
SEVERE LV DYSFUNCTION, EF-27%,
CORONARY ANGIOGRAM DONE ON 18/04/2022 - CAD-SVD (LAD-SCAD)
PTCA+DES TO LAD WITH 3.0 X 24 MM 3V ASTRA DONE ON 18/04/2022

C/o chest pain on and off since 3 days

AT ADMISSION:

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. GATTIAIAH PULIPAKA came with c/o chest pain on and off since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NON ST ELEVATED MI, SR, NO TLT, SEVERE LV DYSFUNCTION, EF-27%, CORONARY ANGIOGRAM DONE ON 18/04/2022 -CAD-SVD (LAD-SCAD), PTCA+DES TO LAD WITH 3.0 X 24 MM 3V ASTRA DONE ON 18/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
- 6) TAB. FRUSELAC 1/2 TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001229979

Name

Mr.
MANDAL
MINTO

Patient Identifier

ARHIP55408

Age

28Yr
0Mth
5Days

Sex

Male

Date of Admission

16-
Apr-
2022

**Date of Discharge
MLC No**

Address

OC
COLONY,Tandur,Telangana

**Ward/
Bed No**

Second
Floor,
Male
General Ward,
Bed
no:GW
15

Primary Consultant

Dr. SURESH GOUD
S(MS,M.Ch
Urology(SVIMS),Consultant
Urologist)--UROLOGY

RIGHT URETERIC CALCULUS
SURGERY: RIGHT URSL+DJ STENTING DONE ON 18.04.2022

C/o right loin pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 28 yrs old male patient Mr. MANDAL MINTO came to the hospital with c/o right loin pain, burning micturition since 7 days. All necessary investigations done and diagnosed as RIGHT URETERIC CALCULUS, SURGERY: RIGHT URSL+DJ STENTING DONE ON 18.04.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE CV 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, SOS
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: NDQ10 ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 11 DAYS, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001229874

Name		Mr. SHANKAR BABU JALAPALLI	
Patient Identifier	ARHIP55368	Age	31Yr 0Mth 9Days
Sex	Male	Date of Admission	13-Apr-2022
Date of Discharge MLC No			
Address	3-77/1 DUMALA,Karimnagar,Telangana	Ward/ Bed No	Second Floor, Male General Ward, Bed no:GW 21
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

POSTERIOR CIRCULATION STROKE SCHIZOPHRENIA

C/o altered sensorium, difficulty in walking, difficulty in swallowing

Known case of hypertension, diabetic mellitus, and schizophrenia on treatment

AT ADMISSION:

Febrile-102 F

PR: 92/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 31 years old male patient Mr. SHANKAR BABU JALAPALLI came with c/o altered sensorium, difficulty in walking, difficulty in swallowing. All necessary investigations were done and diagnosed as POSTERIOR CIRCULATION STROKE, SCHIZOPHRENIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB: CEFTAS 200MG TWICE DAILY AT 8AM 8PM FOR 5DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM 8PM FOR 5DAYS.
3. TAB: ECOSPRIN-AV 150/20 ONCE DAILY AT 8PM FOR 11DAYS.
4. TAB. SUPRADYN ONCE DAILY AT 8AM FOR 11DAYS.

REVIEW AFTER 11DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230
062

Name

Mr.
BONGO
NI KIRAN
KUMAR

**Patient
Identifier** ARHIP55435

Age 40Yr 8Mth
16Days

Sex Male

**Date of
Admission** 19-Apr-2022

**Date of
Discharge**

MLC No

Address 14-86,
mankammathota,karimnagar,Karimnagar,
Telangana

Ward/Bed No First Floor,
RECOVERY ROOM,
Bed no:RR 10

**Primary
Consultant** Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General Surgeon)--
GENERAL SURGERY

Consultants

Surgeons Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General Surgeon)--
GENERAL SURGERY

Anesthesiologists Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY

Diagnosis

S

Diagnosis

[Add
Diagnosis](#)

ARHIP55435	ARH1.000123006
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☐ Surgery / Procedures
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeo ns	Anesthetis ts
LATERAL ANAL SPHINCTEROTOMY,+ ANAL DILATATION				

ACUTE POSTERIOR FISSURE IN ANO

SURGERY: CIRCUMCISSION+LATERAL ANAL SPHINCTEROTOMY+ANAL DILATATION DONE ON 13/05/22

C/o Pain and difficulty during defecation

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 40yr old male patient Mr. BONGONI KIRAN KUMAR came with c/o Pain and difficulty during defecation. All necessary investigations done and diagnosed as ACUTE POSTERIOR FISSURE IN ANO, SURGERY: LATERAL ANAL SPHINCTEROTOMY,+ ANAL DILATATION DONE ON 20/04/22. Findings: Posterior fissure noted with skin tags noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. METROGYL-P OINTMENT THRICE DAILY AT 8AM, 2PM AND 8PM
2. XYLOCAINE JELLY QID
3. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
4. TAB. ND Q10 ONCE IN A DAY AT 2 PM
5. GLUTAVAUULT SACHETS ONCE IN A DAY AT 2 PM

Review after 7 days in General Surgery OPD.

ARH1.0001221501

Name

Mrs. GIRIJA BAI K

Patient Identifier

ARHIP55419

Sex

Female

**Date of Discharge
MLC No**

Address

KARIMNAGAR,Karimnagar,Telangana

Primary Consultant

Dr. GOUTHAM ROY

Age

71Yr 7Mth
5Days

Date of Admission

18-Apr-2022

Ward/Bed No

First Floor,
RECOVERY
ROOM, Bed
no:RR 5

GALLSTONE DISEASE

SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 19.04.2022

C/o pain abdomen, low backache since 5 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 71yr old female patient Mrs. GIRIJA BAI K came with c/o pain abdomen, low backache since 5 days. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 19.04.2022. Findings: Well distended gallbladder with well defined calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 30 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001229965

Name

Mrs.
RAMALAXMI
KOLA

Patient Identifier

ARHIP55404

Age

62Yr
0Mth
5Days

Sex

Female

**Date of
Admission**

16-
Apr-
2022

**Date of Discharge
MLC No**

Address

ASHOKNAGAR,Karimnagar,Telangana

**Ward/Bed
No**

Second
Floor,
Semi
Private
, Bed
no:103
B

Primary Consultant

DR. NIKHIL GOLI --NEUROLOGY

LEFT PCA INFARCT
CAD
PLAN CAG

C/o Sudden onset of right sided weakness

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 62 years old female patient Mrs. RAMALAXMI KOLA came with c/o Sudden onset of right sided weakness. All necessary investigations were done and diagnosed as LEFT PCA INFARCT, CAD, PLAN CAG. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM FOR 11DAYS.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM FOR 11DAYS.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM FOR 11DAYS.
4. TAB. NICARDIA RETARD 10MG ONCE DAILY AT 8AM FOR 11DAYS.

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001230045		Name	Mr. K MOHAN REDDY
Patient Identifier	ARHIP55431	Age	72Yr 0Mth 2Days
Sex	Male	Date of Admission	19-Apr-2022
Expired Date	21-Apr-2022		
MLC No			
Address	ramagundam, peddapally, Karimnagar, Telangana	Ward/Bed No	First Floor, SICU, Bed no: SICU 3
Primary Consultant	Dr. Venkat Reddy Almareddi (MS(Orthopaedics), MBA(Healthcare), Fellow in Joint Replacement, Fellow in Shoulder Surgery(USA), Fellow in Arthroscopy(SIOR), Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	Consultants	
Surgeons	Dr. Venkat Reddy Almareddi (MS(Orthopaedics), MBA(Healthcare), Fellow in Joint Replacement, Fellow in Shoulder Surgery(USA), Fellow in Arthroscopy(SIOR), Consultant Orthopaedic Surgeon)--ORTHOPAEDICS	Anesthesiologists	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

Diagnosis

Diagnosis

Disease	Disease Type
	Pd

CRUSH INJURY OF FOOT AND ANKLE RIGHT, INTERTROCHANTERIC FRACTURE RIGHT FEMUR

DM - DIABETES MELLITUS

Alleged history of RTA, slip and fall under Bus at 8.45 AM on 19/04/2022, sustained crush injury of right lower limb

C/o pain in right foot and ankle, bleeding from right foot.

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-81/min

BP-120/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 72 yrs old male patient Mr. K MOHAN REDDY came with alleged history of RTA, slip and fall under Bus at 8.45 AM on 19/04/2022, sustained crush injury of right lower limb, pain in right foot and ankle, bleeding from right foot. All necessary investigations done and diagnosed as CRUSH INJURY OF FOOT AND ANKLE RIGHT, INTERTROCHANTERIC FRACTURE RIGHT FEMUR, DM - DIABETES MELLITUS. SURGERY: BELOW KNEE AMPUTATION RIGHT done on 19/04/2022. Patient was on ventilator. On 21/04/2022 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 02.48 PM on 21/04/2022.

CAUSE OF DEATH

Postoperative myocardial infarction, crush injury of right foot, below knee amputation

ARH1.0001230028

Name

Mrs. AJAJ
BEGUM

Patient Identifier

ARHIP55428

Age

49Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

19-Apr-
2022

**Date of Discharge
MLC No**

Address

1-1-96/1 HAJI PUR,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ANTERO LATERAL WALL MI, NO TLT, SR
MILD LV DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 16 MM 3V ASTRA [LOT NO: 240130016032A,
S/N :22014161001] DONE ON 19/04/2022

R/F: T2DM

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 90%

P/A: Soft

A 49years old female patient Mrs. AJAJ BEGUM came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ANTERO LATERAL WALL MI, NO TLT, SR, MILD LV DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 16 MM 3V ASTRA LOT NO: 240130016032A, S/N :22014161001 DONE ON 19/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RAMISTAR 2.5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. BETALOC 25 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230069

Name

Mrs.
RUKSANA
BEGUM

Patient Identifier

ARHIP55442

Sex

Female

Age 50Yr 0Mth
2Days

Date of Admission 20-Apr-2022

Date of Discharge

MLC No

Address

4-1-10 VANI
NAGAR,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , ACUTE IWMI, NO TLT, SR

NORMAL LV FUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 21/04/2022 - CAD-DVD

PLAN CABG.

R/F HTN, T2DM, HYPOTHYROIDISM

C/o chest pain, radiating to the back since 5 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 50 years old female patient Mrs. RUKSANA BEGUM came with c/o chest pain, radiating to the back since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , ACUTE IWMI, NO TLT, SR, NORMAL LV FUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 21/04/2022 – CAD-DVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 625 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. TELMA 40 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. THYRONORM 125 MCG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001229926

Name

Mrs. LAXMI
NALLA

Patient Identifier

ARHIP55434

Age

71Yr
0Mth
8Days

Sex

Female

**Date of
Admission**

19-Apr-
2022

Date of Discharge

MLC No

Address

KHANAPUR, Nirmal, Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, NSTEMI, SR

MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%]

CORONARY ANGIOGRAM (21/04/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest pain a/w SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 71 years old female patient Mrs. LAXMI NALLA came with c/o chest pain a/w SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, SR, MODERATE LV SYSTOLIC DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM (21/04/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ROZAGOLD 20MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CARDIVAS 6.125 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
3. TAB. SOBINIX ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. KETO CHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. CUDCE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. TAB. ALCYSTA ONCE DAILY AT 2PM TO CONTINUE.
7. TAB: LASIX 40 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001193367

Name	Mrs. CHANDRAMMA JEEREDDI		
Patient Identifier	ARHIP55456	Age	59Yr 6Mth 29Days
Sex	Female	Date of Admission	21-Apr-2022
Date of Discharge			
MLC No			
Address	12-129, SARDAR VALLABAI NAGAR, KYATHANPALLI, MD MANDAMARRI,Mancherial,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU11
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

DCMP, ADHF, SEVERE MR, MILD P.R, SEVERE TR

SEVERE LV SYSTOLIC DYSFUNCTION [EF-20%]

R/F : T2DM, HYPOTHYROIDISM

C/o shortness of breath grade 3-4 since 1 month aggravated since 3 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 92/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 59 years old female patient Mrs. CHANDRAMMA JEEREDDI came with c/o shortness of breath grade 3-4 since 1 month aggravated since 3 days. All necessary investigations were done and diagnosed as DCMP, ADHF, SEVERE MR, MILD P.R, SEVERE TR, SEVERE LV SYSTOLIC DYSFUNCTION [EF-20%], R/F : T2DM, HYPOTHYROIDISM. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. DYTOR PLUS 20MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. DYTOR 5MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. FLAVIDONE MR 35MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
4. TAB. ELIQUIS 5MG TWICE DAILY AT 8AM 8PM TO CONTINUE.
5. TAB. THYRONORM 25 MCG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS

ARH1.0001061466

		Name	Mrs. REGULAPATI ANSURYA	
Patient Identifier	ARHIP5446	Age	53Yr 9Mth 9Days	
Sex	Female	Date of Admission	20-Apr-2022	
Date of Discharge				
MLC No				
Address	CHINTHALATANA, SIRCILLA,Karimnagar,Andhra Pradesh		Ward/ Bed No	First Floor, CICU , Bed no:CICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

NORMAL LV FUNCTION [EF-65%]

CORONARY ANGIOGRAM (22/04/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

R/F : HTN, T2DM, HYPERLIPIDEMIA, Br. ASTHMA

C/o chest pain, radiating to back, difficulty in breathing since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 53 years old female patient Mrs. REGULAPATI ANSURYA came with c/o chest pain, radiating to back, difficulty in breathing since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV FUNCTION [EF-65%], CORONARY ANGIOGRAM (22/04/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVAS 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. TELLZY 20MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. THYRONORM 75MCG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

APJ1.0001988412

Name

Mrs. T
SUNITHA

Patient Identifier

ARHIP55367

Age

52Yr
5Mth
28Days

Sex

Female

Date of Admission

13-Apr-2022

**Date of Discharge
MLC No**

Address

Q NO B-5/79(PTS), JYOTHI
NAGAR,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 2

Primary Consultant

Dr Chandra Shekar Sathineni

ACUTE GASTROENTERITIS
UPPER GI BLEED
D K A

C/o pain abdomen, 5-6 episodes of vomitings

Known case of hypertension, Denovo diabetes mellitus
Known case of schizophrenia on irregular medication
Known case of ovarian cancer on 6 cycles of chemotherapy
Known case of DVT on medication

AT ADMISSION:

Afebrile

PR: 76/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old female patient Mrs. T SUNITHA came with c/o pain abdomen, 5-6 episodes of vomiting, Known case of hypertension, Denovo diabetes mellitus, Known case of schizophrenia on irregular medication, Known case of ovarian cancer on 6 cycles of chemotherapy, Known case of DVT on medication. All necessary investigations were done and diagnosed as ACUTE GASTROENTERITIS, UPPER GI BLEED, D K A. Central line placed on 13/04/22, Upper GI endoscopy done shows diffuse oesophageal ulceration, Patient Hb 7.9 mg/dL, 2 units of PCV transfusion given, Platelet count was 39 K 1 unit SDP transfusion given, Platelet count increased to 55K, CBP monitoring done. Patient was managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. CEFUTIC 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. DAPARYL 10 MG ONCE DAILY AT 2PM FOR 5 DAYS
- 4) TAB. RAZO-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

shahin

Patient presented with the above-mentioned complaints. Patient was treated with IV fluids actrapid infusion and CEFTAZIDIME and TAZOBACTAM. Daily ABG monitoring was done daily blood sugars were monitored patient was treated as diabetic ketoacidosis with underlying cardiogenic shock. 2D echo revealed severe LV dysfunction with inferior wall akinesia, Cardiologist consultation taken and planned CAG at a later date.

Now the patient is symptomatically better the blood pressure is 80 x 50 mm of Hg, the patient is advised further stay in hospital but attenders are unwilling so patient is being discharged at request.

diabetic ketoacidosis
cardiogenic shock probable CAD with LV dysfunction

sudhakar rao

Patient presented with the above-mentioned complaints patient was diagnosed to have neuroglycopenia as patient had blood sugars of 26 mg/dL on arrival. Patient was treated with 25% DEXTROSE 100 mL and then put on 5% DEXTROSE Infusion at 30 cc/hour. Now the patient is symptomatically better and haemodynamically stable and is maintaining saturation on room air. The patient has been advised further stay but the patient is unwilling so patient is being discharged at request.

ARH1.0001230067

		Name	Mr. MOHAMMED ABDUL RAHAMAN	
Patient Identifier	ARHIP55440	Age	44Yr 0Mth 4Days	
Sex	Male	Date of Admission	19-Apr-2022	
Date of Discharge				
MLC No				
Address	H.NO:5-3-6,HAZARA PURA,JAGITIAL,Telangana		Ward/ Bed No	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-55%

CORONARY ANGIOGRAM DONE ON 20/04/2022 - CAD-SVD (RCA)

PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR [LOT NO: MH32, S/N :CM19MH32020]
DONE ON 20/04/2022

C/o Retrosternal chest pain a/w sweating since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 44 years old male patient Mr. MOHAMMED ABDUL RAHAMAN came with c/o retrosternal chest pain a/w sweating since 3 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-55%, CORONARY ANGIOGRAM DONE ON 20/04/2022 - CAD-SVD (RCA), PTCA+DES TO RCA WITH 3.0 X 19 MM METAFOR [LOT NO: MH32, S/N :CM19MH32020] DONE ON 20/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. CILODOC 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 4) TAB. STARVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001155099

		Mr. VELAMA SUDHAKAR RAO	
Patient Identifier	ARHIP55470	Age	74Yr 6Mth 8Days
Sex	Male	Date of Admission	22-Apr-2022
Date of Discharge			
MLC No			
Address	SSC RESIDENCIAL, NEAR GEETHA BHAVAN, KARIMNAGAR,Karimnagar,Telangana		
Primary Consultant	DR. SRI KARAN UDDESH --INTERNAL		
		Ward/ Bed No	First Floor, MICU, Bed no:MICU 8

NEUROGLYCOPENIA

AKI

S/P PPI, Pleural TB on treatment since 1 month

Diabetic Mellitus, Hypertension

Patient is drowsy

C/o shortness of breath and diaphoresis before the onset of drowsiness

H/o patient on ATT treatment since 21/03/22

AT ADMISSION:

Patient is drowsy

PR: 87/min

BP: 160/80mmHg

RS: BAE+

CVS: S1S2

RR: 26/min

SPO2: 98% on 14 Litrs O2

P/A: Soft

A 74-year-old male patient Mr. VELAMA SUDHAKAR RAO presented with the above-mentioned complaints. Patient was diagnosed to have neuroglycopenia as patient had blood sugars of 26 mg/dL on arrival. Patient was treated with 25% DEXTROSE 100 mL and then put on 5% DEXTROSE Infusion at 30 cc/hour. Now the patient is symptomatically better and haemodynamically stable and is maintaining saturation on room air. The patient has been advised further stay, but the patient is unwilling. So patient is being discharged at request.

DISCHARGE MEDICATION:

1. TAB. R-CINEX 600/300 ONCE AT 8AM BBF FOR 7 DAYS
2. TAB. COMBUTAL 600 MG ONCE AT 8AM FOR 7 DAYS
3. TAB. PYZENA 750 MG ONCE AT 8AM FOR 7 DAYS
4. TAB. BENADON 40 MG ONCE AT 8AM FOR 7 DAYS
5. TAB. ATENOLOL 25 MG ONCE AT 8AM FOR 7 DAYS
6. TAB. PAN 40 MG ONCE AT 7AM BBF FOR 7 DAYS
7. NEB WITH DUOLIN, BUDECORT 1 Resp THRICE DAILY AT 8AM 2PM 8PM
8. WITH HOLD INSULIN FOR 24 HRS

REVIEW WITH FBS, PLBS REPORTS AFTER 2 DAYS IN GENERAL MEDICINE OPD

ARH1.0001230065

		Name	Mr. LAXMANA CHARY KOHEDA	
Patient Identifier	ARHIP55439	Age	61Yr 0Mth 4Days	
Sex	Male	Date of Admission	19-Apr-2022	
Date of Discharge				
MLC No				
Address	H.NO:8-3-414,BHAGATHNAGAR,Karimnagar,Telangana		Ward/ Bed No	First Floor, RECOVERY ROOM, Bed no:RR 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, IWMI, NO TLT, SR

NORMAL LV DYSFUNCTION, EF-60%

CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-SVD (LCX)

PTCA+DES TO LAD WITH 2.5 X 16 MM METAFOR [LOT NO: MG93, S/N :CS16MG93010]
DONE ON 19/04/2022

R/F: ALCOHOLIC

C/o sudden chest pain a/w profuse sweating since 3 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 61 years old male patient Mr. LAXMANA CHARY KOHEDA came with c/o sudden chest pain a/w profuse sweating since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, IWMI, NO TLT, SR, NORMAL LV DYSFUNCTION, EF-60%, CORONARY ANGIOGRAM DONE ON 19/04/2022 - CAD-SVD (LCX), PTCA+DES TO LAD WITH 2.5 X 16 MM METAFOR [LOT NO: MG93, S/N :CS16MG93010] DONE ON 19/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.00012300 23	ARHIP554 22	Mrs. SHAHEEN BEGUM Female 40Yr 0Mth 5Days	123 C	18-Apr- 2022	DR. SRI KARAN UDDESH
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DIABETIC KETOACIDOSIS
CARDIOGENIC SHOCK
PROBABLE CAD WITH LV DYSFUNCTION

C/o fever with chills since 4-5 days multiple episodes of vomiting associated with shortness of breath and drowsy since 1 day

Known case of hypertension diabetes mellitus on regular treatment

AT ADMISSION:

Patient is drowsy

PR: 101/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 34/min

SPO2: 99% on room air

P/A: tenderness is observed on superficial palpation

A 40-year-old female patient Mrs. SHAHEEN BEGUM patient presented with the above-mentioned complaints. Patient was treated with IV fluids, human actrapid infusion and CEFTAZIDIME and TAZOBACTAM. Daily ABG monitoring was done, daily blood sugars were monitored. Patient was treated as diabetic ketoacidosis with underlying cardiogenic shock. 2D echo revealed severe LV dysfunction with inferior wall akinesia, Cardiologist consultation taken and planned CAG at a later date. Now the patient is symptomatically better the blood pressure is 80 / 50 mmHg, the patient is advised further stay in hospital but attenders are unwilling. So patient is being discharged at request.

DISCHARGE MEDICATION:

1. INJ. LANTUS 10 U S/C ONCE AT 8PM FOR 7 DAYS
2. INJ. APIDRA THRICE DAILY S/C 6 U AT 8AM, 6U AT 2PM, 4U AT 8PM FOR 7 DAYS
3. TAB. DAPAGLYN-M 5/500 TWICE DAILY AT 8AM, 8PM FOR 7 DAYS
4. TAB. ROSUVAS GOLD ONCE AT 2PM FOR 7 DAYS
5. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM 2PM 8PM FOR 3 DAYS

REVIEW WITH FBS, PLBS REPORTS AFTER 7 DAYS IN GENERAL MEDICINE OPD & TO MEET CARDIOLOGIST FOR CAG.

55462 pochaiah 47

CORONARY ARTERY DISEASE, AWTMI, NO TLT R, MILD MR, MILD TR/PAH

MODERATE LV DYSFUNCTION, EF-36%

CORONARY ANGIOGRAM DONE ON 21/04/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 28 MM 3V ASTRA [LOT NO: 240335028042A, S/N :22035282099] DONE ON 21/04/2022

R/F: HTN, T2DM

C/o chest pain, profse sweating and vomiting and SOB since 1 days

AT ADMISSION:

Afebrile

PR: 118/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 47years old male patient Mr. POCHIAIH came with c/o chest pain, profse sweating and vomiting and SOB since 1 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, NO TLT R, MILD MR, MILD TR/PAH, MODERATE LV DYSFUNCTION, EF-36%, CORONARY ANGIOGRAM DONE ON 21/04/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 28 MM 3V ASTRA [LOT NO: 240335028042A, S/N :22035282099] DONE ON 21/04/2022. Post procedure is

uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET R 25/2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 11 DAYS.

DIET MANAGEMENT FOR DM

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230088

Name

Mrs. LAXMI D

Patient Identifier

ARHIP55449

Age

60Yr
0Mth
5Days

Sex

Female

Date of Admission

20-Apr-2022

**Date of Discharge
MLC No**

Address

RAMAKRISHNAPUR,,Mancheria,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , NSTEMI, NO TLT, SR

MILD LV SYSTOLIC DYSFUNCTION, EF-50%

S/P CORONARY ANGIOGRAM DONE ON 23/04/2022 - CAD-TVD

PLAN CABG.

R/F T2DM, HTN

C/o chest pain, SOB since 2 months

At Admission

Afebrile

PR: 80/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 60 years old female patient D. LAXMI came with c/o chest pain, SOB since 2 months. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, NO TLT, SR, MILD LV SYSTOLIC DYSFUNCTION, EF-56%, S/P CORONARY ANGIOGRAM DONE ON 23/04/2022 - CAD-TVD, PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

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ARH1.0001210161		Name	Mr. RAJALINGU Y
Patient Identifier	ARHIP55486	Age	67Yr 11Mth 5Days
Sex	Male	Date of Admission	24-Apr-2022
Date of Discharge			
MLC No			
Address	RAMAKRISHNAPUR,Telangana	Ward/ Bed No	Ground Floor, Emergency Ward, Bed no:EME2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

ACUTE DECOMPENSATED HEART FAILURE
DCMP, MILD MR, SEVERE LV SYSTOLIC DYSFUNCTION EF, 30%
CORONARY ANGIOGRAM (07/2021) -NORMAL CORONARIES

R/F: HYPERTENSION

C/o shortness of breath grade-3 since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 67 years old male patient Mr. RAJALINGU Y came with c/o shortness of breath grade-3 since 7 days. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE, DCMP, MILD MR, SEVERE LV SYSTOLIC DYSFUNCTION EF, 30%, CORONARY ANGIOGRAM (07/2021) - NORMAL CORONARIES, R/F: HYPERTENSION. Managed conservatively. Patient attendants want to discharge, hence patient getting discharged on LAMA.

DISCHARGE MEDICATION:

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. LANOXIN 0.25 MG ½ TAB ONCE DAILY AT 2PM TO CONTINUE 5/7.
3. TAB: CARDIVAS 3.125MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB: RAMISTAR 1.25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. DYTOR PLUS 10 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001230264

Name

Mrs.
RAPELly
THARA

Patient Identifier

ARHIP55497

Age

49Yr
3Mth
25Days

Sex

Female

**Date of
Admission**

25-Apr-
2022

**Date of Discharge
MLC No**

Address

abbapur,jualapallya,peddapally,Karimnagar,Tel
angana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no:SICU
3

Primary Consultant

DR. SUBRAT KUMAR SOREN --NEUROSURGERY

RTA
SEVERE TRAUMATIC BRAIN INJURY
DIFFUSE AXONAL INJURY
TRAUMATIC SAH
FRACTURE NECK OF RIGHT HUMERUS
FRACTURE MAXILLA RIGHT SIDE

A case of RTA, polytrauma followed by RTA at 1 p.m. on 25/04/2022 at Peddapally
Patient has unresponsive since RTA
History of abrasions on head, right shoulder

PHYSICAL EXAMINATION:

ON ADMISSION

PR-76/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

P/A-Soft

SPO2-95%

GCS: E1,V1,M3

A 49 yrs old female patient Mrs. RAPELly THARA, a case of RTA, polytrauma at 1 p.m. on 25/04/2022 at Peddapally, Patient has unresponsive since RTA, History of abrasions on head, right shoulder. All necessary investigations done and diagnosed as RTA, SEVERE TRAUMATIC BRAIN INJURY, DIFFUSE AXONAL INJURY TRAUMATIC SAH, FRACTURE NECK OF RIGHT HUMERUS, FRACTURE MAXILLA RIGHT SIDE. Orthopaedic consultation taken and advice followed. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001230238

Name	Mr. SRINIVAS REGALLA		
Patient Identifier	ARHIP55493	Age	57Yr 2Mth 11Days
Sex	Male	Date of Admission	25-Apr-2022
Date of Discharge			
MLC No			
Address	D.NO 12-640/1 HANUMAN NAGAR,Mancherla,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE , IWMI, SR, NO TLT

NORMAL LV SYSTOLIC DYSFUNCTION, EF-60%

S/P CORONARY ANGIOGRAM DONE ON 25/04/2022 - CAD-TVD (LAD, LCX, RCA)

PLAN CABG.

R/F HTN, T2DM, SMOKING

C/o Retrosternal chest pain, radiating to the back a/w sweating since 1 day

At Admission

Afebrile

PR: 86/min

BP: 90/60 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 57 years old male patient Mr. SRINIVAS REGALLA came with c/o retrosternal chest pain, radiating to the back a/w sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , IWMI, SR, NO TLT, NORMAL LV SYSTOLIC DYSFUNCTION, EF-60%, S/P CORONARY ANGIOGRAM DONE ON 25/04/2022 - CAD-TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. ANGISPAN TR **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001230220

Name

Mr. B
KISHAN
RAO

Patient Identifier

ARHIP55478

Age

52Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

23-Apr-
2022

**Date of Discharge
MLC No**

Address

VEERAPUR RAIKAL
JAGITIAL, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
9

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT

MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%

CORONARY ANGIOGRAM DONE ON 23/04/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 3.5 X 18 MM BIOFREEDOM [LOT NO: VV20110360, S/N :BFR13518] DONE ON 23/04/2022

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 52 years old male patient Mr. B KISHAN RAO came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWMI, SR, NO TLT, MODERATE LV SYSTOLIC DYSFUNCTION, EF-35%, CORONARY ANGIOGRAM DONE ON 23/04/2022 – CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 3.5 X 18 MM BIOFREEDOM [LOT NO: VV20110360, S/N :BFR13518] DONE ON 23/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PROLOMET-T 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. VELOZ 20 MG ONCE DAILY AT 2PM TO CONTINUE.

LIFE STYLE MODIFICATIONS FOR DM/HTN

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230218

Name

Mr.
JANARDHAN
SHARMA
MADHU

Patient Identifier

ARHIP55481

Age

80Yr
0Mth
3Days

Sex

Male

Date of Admission

23-Apr-
2022

Date of Discharge

MLC No

Address

DISTRICT: KARIMNAGAR,Other,Telangana

Ward/Bed No

First
Floor,
SICU,
Bed
no:SICU
7

Primary Consultant

Dr. GOUTHAM ROY (MS(General

LARGE BOWEL INTESTINAL OBSTRUCTION SECONDARY TO ? CA RECTOSIGMOID JUNCTION
WITH IHD WITH KNOWN CASE OF EPTB

C/o pain abdomen since 15 days

Diarrhoea since 15 days

Vomitings since 2 days

Decreased urine output since 1 day

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 80 years old male patient Mr. JANARDHAN SHARMA MADHU came with c/o pain abdomen since 15 days, Diarrhoea since 15 days, Vomitings since 2 days, Decreased urine output since 1 day. All necessary investigations were done and diagnosed as LARGE BOWEL INTESINAL OBSTRUCTION SECONDARY TO ? CA RECTOSIGMOID JUNCTION WITH IHD WITH KNOWN CASE OF EPTB . As patient attendants were not willing for surgery at high risk.

As the patient attenders were not willing for surgery at high risk hence patient discharge at request

ARH1.0001145044

Name

Mr. MOHAN
REDDY Y

**Patient
Identifier**

ARHIP55276

Age

64Yr
4Mth
10Days

Sex

Male

**Date of
Admission**

02-Apr-
2022

**Expired Date
MLC No**

03-Apr-2022

Address

MALLAPUR
THIMMAPUR, Karimnagar, Telangana


Ward/Bed No

First
Floor,
CICU ,
Bed
no: CICU
3

**Primary
Consultant
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants
Anesthesiologi
sts**

 **Diagnosis**
S

Diagnosis

Disease	Disease Type
ACUTE PULMONARY EDEMA, ACUTE DECOMPRESSIVE HEART FAILURE.	

C/o chest pain since 2 days

AT ADMISSION:

PR: 89/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 64 years old male patient Mr. MOHAN REDDY Y came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as ACUTE PULMONARY EDEMA, ACUTE DECOMPRESSIVE HEART FAILURE. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 06.07 PM on 03/04/2022.

ARH1.0001230098

Name	Mr. T RAVI
Patient Identifier	ARHIP55450
Age	40Yr 0Mth 7Days
Sex	Male
Date of Admission	20-Apr-2022
Date of Discharge	21-Apr-2022
MLC No	
Address	GODAVARIKHANI,Karimnagar,Telangana
Ward/Bed No	First Floor, CICU , Bed no:CICU11
Primary Consultant Surgeons	Dr. Vidya Sagar A--CARDIOLOGY
Consultants Anesthesiologists	

Diagnosis

Diagnosis

Disease	Disease Type
ACUTE INFERIOR WALL MIOCARDIAL INFARCTION WITH LOWER RESPIRATORY TRACT INFECTION.	

C/o chest pain since 3 days

Severe SOB since 1 day

AT ADMISSION:

PR: 71/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 92%

P/A: Soft

A 40 years old male patient ^{Mr. T RAVI} came with c/o chest pain since 3 days, severe SOB since 1 day. All necessary investigations were done and diagnosed as ACUTE INFERIOR WALL MIOCARDIAL INFARCTION WITH LOWER RESPIRATORY TRACT INFECTION. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. Patient reverted to NSR. Again at 9.45 AM on 21/04/2022 patient developed bradycardia, CPR was given and continued but patient not everted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 10.25 AM on 21/04/2022.

CAUSE OF DEATH

SUDDEN CARDIOPULMONARY ARREST SECONDARY TO ACUTE INFERIOR WALL MIOCARDIAL INFARCTION WITH LOWER RESPIRATORY TRACT INFECTION.

ARH1.0001229898

Name

Mrs. VENKATA
LAXMI

Patient
Identifier

ARHIP55376

Age

40Yr
0Mth
2Days

Sex

Female

Date of
Admission

13-Apr-
2022

Expired Date

15-Apr-2022

MLC No

Address

Thadecharla
Bhopalpalli,Adilabad(Adilabad),Telangan
a

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
2

Primary
Consultant
Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Consultants
Anesthesiologi
sts

Diagnosi
S

Diagnosis

Diseas
e Disease
Type

SEPTIC SHOCK CHRONIC RHEUMATIC HEART DISEASE,SEVERE MITRAL REGURGITATION,SEVERE PULMONARY ARTERIAL HYPERTENSION,SINUS RHYTHM,LOWER RESPIRATORY TRACT INFECTION(? PNEUMONOA)THROMBOCYTOPENIA,RESPIRATORY ACIDOSIS

C/o sudden syncope at home, followed by blurring of vision

AT ADMISSION:

PR: 124/min

BP: 60/__mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 80%

P/A: Soft

A 40 years old female patient Mrs. VENKATA LAXMI came with c/o sudden syncope at home, followed by blurring of vision. All necessary investigations were done and diagnosed as SEPTIC SHOCK CHRONIC RHEUMATIC HEART DISEASE, SEVERE MITRAL REGURGITATION, SEVERE PULMONARY ARTERIAL HYPERTENSION, SINUS RHYTHM, LOWER RESPIRATORY TRACT INFECTION(? PNEUMONIA) THROMBOCYTOPENIA, RESPIRATORY ACIDOSIS. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 40 minutes, according to ACLS guidelines. Patient developed bradycardia, CPR was given and continued but patient not everted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 04.43 PM on 15/04/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST WITH SEPTIC SHOCK, CRHD, RESPIRATORY ACIDOSIS WITH THROMBOCYTOPENIA .

ARH1.0001230232

Name

Mrs. LAXMI
THIPARAPU

**Patient
Identifier**

ARHIP55490

Age

54Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

24-Apr-
2022

**Date of
Discharge
MLC No**

Address

MYLARAM,Karimnagar,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

**Primary
Consultant**

Dr. Vidya Sagar A--
CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR

MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 24/04/2022 - CAD-TVD (LAD, LCX, RCA)

PTCA+DES TO RCA WITH 3.0 X 16 MM METAFOR DONE ON 24/04/2022
CABG LATER

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54years old female patient Mrs. LAXMI THIPARAPU came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, NO TLT, SR, MODERATE LV SYSTOLIC DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 24/04/2022 - CAD-TVD (LAD, LCX, RCA), PTCA+DES TO RCA WITH 3.0 X 16 MM METAFOR DONE ON 24/04/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 3) TAB. TONACT 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 5) LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001230136

Name

Mr. SYED
ASADULLA
HUSSAIN

Patient Identifier

ARHIP55459

Age 62Yr 0Mth
6Days

Sex

Male

Date of Admission 21-Apr-2022

Date of Discharge
MLC No

Address

hussenipura,Karimnagar,Telangana

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU1
0

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMi, NO TLT, SR, MILD MR

LV APICAL CLOT 2.6 X 1.6 CM,

POSTERIOR 2.5 CM EFFUSION

SEVERE LV SYSTOLIC DYSFUNCTION, EF-25%

CORONARY ANGIOGRAM DONE ON 24/04/2022 - CAD-TVD (LAD, LCX, RCA)

PTCA+DES TO RCA WITH 3.0 X 16 MM METAFOR DONE ON 24/04/2022
RECOVERED FROM CARDIOGENIC SHOCK

AF ---> SR, AMIDARONE

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 years old male patient Mr. SYED ASADULLA HUSSAIN came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, NO TLT, SR, MILD MR, LV APICAL CLOT 2.6 X 1.6 CM, POSTERIOR 2.5 CM EFFUSION, SEVERE LV SYSTOLIC DYSFUNCTION, EF-25%, CORONARY ANGIOGRAM DONE ON 24/04/2022 - CAD-TVD (LAD, LCX, RCA), PTCA+DES TO RCA WITH 3.0 X 16 MM METAFOR DONE ON 24/04/2022, RECOVERED FROM CARDIOGENIC SHOCK, AF ---> SR, AMIDARONE. Post procedure is uneventful. High risk and poor prognosis explained to patient attender. Patient is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. DISPRIN 325MG WITH CUP OF WATER 4 TIMES DAILY TO CONTINUE.
- 2) TAB. CLOPITAB 75MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. IXAROLA 15MG ONCE DAILY AT 8PM AFTER DINNER TO CONTINUE.
- 4) TAB. TONACT 20MG ONCE DAILY AT 8PM AFTER DINNER TO CONTINUE.
- 5) TAB. CORDARONE X 200MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
- 6) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 7) TAB. RESTYL 0.25 MG ONCE DAILY AT 8PM FOR 10 DAYS
- 8) LIFE STYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

https://cgs.login.ap2.oraclecloud.com/oam/server/obrareq.cgi?encquery%3Dxyh0HxdUKxErDAXLTyRiqHbbfuonnbm%2BLhKC%2Fc1bzcawAIBCXOAuc%2BnoAhj7sQxuSjdDunvKR0sybSoL4SnftLhGFphIjE2cr%2BJLNv11Z8xYML9Vj9C6h%2BkOR54Wm8mJwqweFD5kRCrA3J1oBR8girrKq5XSrNyepIp0bHShRrulKGL00CLmpIAofYy39oBEXuRm3MmjxNkWt5NNuWl%2F8Fh%2FIyLtZCMVb1RoxWnUuvNZIv0H5uQOGvBDaUxX%2B2IbcOPjqAtLp6eNe7T1gIL2N3JQUuF%2B5eGu8s%2BwRUdYQP1wePefeiJ3o%2F1YMj7oF9DlaFNK0CJXbOT%2ByDbV8DzGfHdlsb4e9tQtR%2BIHfqRv9JtWoidok4K1ERgVGjVgOD8RADEZpKn3aH6692vrIFenFWKvVXtf5yexMM4i7x1psKHiMAeJ7LcM%2FGp0%2BpvR2qvq8o9i9MnmCevZH5Md4tQGI7vukqxsCVoRb4UGA43CpktRd2o5t7HaBxrqLO74nga%20agentid%3DOraFusionApp_11AG%20ver%3D1%20crmethod%3D2%26cksum%3Da87b2811a65b24f1a3ea3dd2f769c0302e4182e3&ECID-Context=1.005T92MvKb23V825Rrp2id0001hh0001at%3BkXhgv0ZCLILIFV8QZTPL9V9O%5EMPgpKSO_UOTdJPOoPRRiG

ARH1.0001232492		Name	Mr. RAJESHAM VASAM
Patient Identifier	ARHIP56435	Age	53Yr 0Mth 19Days
Sex	Male	Date of Admission	01-Jul-2022
Date of Discharge			
MLC No			
Address	H.NO:1-38/1,MUNJAMPALLY,KARIMNAGAR,Karimnagar,Telangana	Ward/Bed No	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS		

CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + HTN+DM S/P IWMI

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA, OM] DONE ON 08/07/2022.

C/o chest pain a/w SOB since 3 days

K/c/o T2DM, HTN

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-110/70mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 53 years old male patient Mr. RAJESHAM VASAM presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + LMCA+TRIPLE VESSEL DISEASE + HTN+DM S/P IWMI, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA, OM] DONE ON 08/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, EF-48%, NO PE/CLOT/VEG

BMI is 20.3 kg/m².

Sr. Creatinine report on 09.07.2022 2.1 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PROLOMET-XL 25MG TWICE DAILY AT 8AM AND 8 PM TO CONTINUE.
- 6) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 7) TAB. ROXSAFE 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 9) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 10) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001232404

Name

Mr. MOHD
AZEEMUDDIN

Patient Identifier

ARHIP56279

Age

84Yr
0Mth
22Days

Sex

Male

**Date of
Admission**

21-Jun-
2022

**Date of Discharge
MLC No**

22-Jun-2022

Address

SAHETH NAGAR
KARIMNAGAR,Karimnagar,Telangana

Ward/Bed No

First
Floor,
HDU,
Bed
no:HD
U 5


Primary Consultant

Dr Chandra Shekar Sathineni(MD
(Internal Medicine))--INTERNAL
MEDICINE

Consultants

Surgeons

Anesthesiologists

 **Diagnosis**
S

Diagnosis

Disease	Disease Type
---------	--------------

METABOLIC ENCEPHELOPATHY
AFI
UROSEPSIS.

C/o unresponsiveness since 1 day

AT ADMISSION:

Afebrile

PR: 85/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 85 years old male patient Mr. MOHD AZEEMUDDIN came with c/o unresponsiveness since 1 day. All necessary investigations were done and diagnosed as METABOLIC ENCEPHELOPATHY, AFI, UROSEPSIS. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

ARH1.0001225739

Name	Mr. BANDARI RAMESH
Patient Identifier	ARHIP56195
Age	27Yr 7Mth 27Days
Sex	Male
Date of Admission	15-Jun-2022
Expired Date	17-Jun-2022
MLC No	
Address	2-75/1/A, ELLANTHAKUNTA RAJANNA 9441773326,Telangana
Ward/Bed No	First Floor, MICU, Bed no:MICU 5
Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY) (NIMS),RENAL TRANSPLANT PHYSICIAN)-- NEPHROLOGY
Surgeons	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)-- UROLOGY
Consultants	
Anesthesiologists	

Diagnosis
S

Diagnosis

Disease	Disease Type
SEPTIC SHOCK WITH MODS, AND UROSEPSIS WITH BILATERAL RENAL CALCULI.	

C/o Left flank pain , shortness of breath, decreased urine output

AT ADMISSION:

PR: 120/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 27 years old male patient Mr. BANDARI RAMESH came with c/o Left flank pain , shortness of breath, decreased urine output. All necessary investigations were done and diagnosed as SEPTIC SHOCK WITH MODS, AND UROSEPSIS WITH BILATERAL RENAL CALCULI. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLS guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.40 AM on 17/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST DUE TO SEPTIC SHOCK WITH MODS AND UROSEPSIS WITH BILATERAL RENAL CALCULI

ARH1.0001232219		Name	Mr. SANTHOSH BHEEMA
Patient Identifier	ARHIP56337	Age	25Yr 0Mth 27Days
Sex	Male	Date of Admission	25-Jun-2022
Date of Discharge	27-Jun-2022		
MLC No			
Address	MALLANNAPET, GOLLAPALLI,JAGITIAL,Karimnagar,Telangan a	Ward/Bed No	First Floor, HDU, Bed no:HD U 5
Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY)(NIMS),RENAL TRANSPLANT PHYSICIAN)--NEPHROLOGY	Consultants	
Surgeons		Anesthesiologists	

Diagnosis

Diagnosis

Disease	Disease
---------	---------

	Type
PARAQUAT POISONING WITH MODS AKI HEPATITIS MUCOSITIS.	

Alleged history of consumption of **paraquat** pesticide unknown quantity at his residence followed by vomiting, SOB

AT ADMISSION:

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 25 years old male patient MR. SANTHOSH BHEEMA came with alleged history of consumption of **paraquat** pesticide unknown quantity at his residence followed by vomiting, SOB . All necessary investigations were done and diagnosed as PARAQUAT POISONING WITH MODS, AKI, HEPATITIS, MUCOSITIS. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 30 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 01.56 PM on 27/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO PARAQUAT POISONING WITH MODS
AKI, HEPATITIS, MUCOSITIS.

ARH1.0001232025

Name

Mr. SURAKANTI
ADHIREDDY

Patient Identifier

ARHIP56127

Age

56Yr
5Mth
13Days

Sex

Male

Date of
Admission

11-Jun-
2022

Expired Date
MLC No

14-Jun-2022

Address

3-212,JAGTIAL,Karimnagar,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MICU
8

Primary Consultant

Dr. RAMCHANDER
TORREM(DM(NEPHROLOGY)
(NIMS),RENAL TRANSPLANT PHYSICIAN)--
NEPHROLOGY

Consultants

Surgeons

Anesthesiologi
sts

Diagnosis
S

Diagnosis

Disease	Disease Type
MODS POISONING WITH PARAQUAT,PROFENOFOS,CYPERMETHRIN	

Alleged history of consumption of **paraquat** poison 40 to 125 ml at 2.30 PM on 11/06/2022, initially gastric lavage done at outside hospital and came here for further management

AT ADMISSION:

PR: 130/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 56 years old male patient Mr. SURAKANTI ADHIREDDY came with alleged history of consumption of **paraquat** poison 40 to 125 ml at 2.30 PM on 11/06/2022, initially gastric lavage done at outside hospital and came here for further management. All necessary investigations were done and diagnosed as MODS, POISONING WITH PARAQUAT,PROFENOFOS,CYPERMETHRIN. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 30 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 07.39 PM on 14/06/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO MODS, POISONING WITH PARAQUAT,PROFENOFOS,CYPERMETHRIN .

ARH1.0001222811

Name	Mr. SRINIVAS DURGAM
Patient Identifier	ARHIP56439
Sex	Male
Expired Date	03-Jul-2022
MLC No	
Address	REKURTHY,KARIMNAGAR,KARIMNAGAR,TELANGANA
Primary Consultant	DR. SANJAY KUMAR KAMINWAR(MD,DM(NEUROLOGY),CONSULTANT NEURO PHYSICIAN)--NEUROLOGY
Surgeons	
Age	39Yr 8Mth 16Days
Date of Admission	01-Jul-2022
Ward/Bed No	FIRST FLOOR, MICU, BED NO:MICU 3
CONSULTANTS	
ANESTHESIOLOGISTS	

Cause of Death

SUDDEN CARDIO PUL

Cause of Death

Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

CVA WITH RIGHT BASAL GANGLIA BLEED.

C/o Sudden onset of left sided weakness associated with slurring of speech and deviation of angle of mouth
Known case of hypertension not on medication

ADMISSION VITALS:

PR-80/min

BP-130/70mmhg

RR-22/mmin

RS-BAE+

CVS-S1S2+

P/A-soft

SPO2-98%

A 39 years old male patient Mr. SRINIVAS DURGAM presented to ER with c/o fever since 5 days, decreased food intake, drowsiness, altered sensorium since few days. All necessary investigations were done and diagnosed as CVA WITH RIGHT BASAL GANGLIA BLEED. On 03.07.2022 at 10.15 AM patient was developed bradycardia, patient was intubated and connected mechanical ventilator . CPR was initiated as per ACLS protocols, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 10.27 AM on 03/07/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONDARY TO CVA WITH RIGHT BASAL GANGLIA BLEED.

ARH1.0001232184

Name

Mr. MARUTHI
REDDYGANI

Patient
Identifier

ARHIP56196

Age

16Yr
0Mth
28Days

Sex

Male

Date of
Admission

15-Jun-
2022

Date of
Discharge
MLC No

21-Jun-2022

Address

3-35, NEDUNUR,KARIMNAGAR,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MICU
8

Primary
Consultant
Surgeons

DR. NIKHIL GOLI --NEUROLOGY

Consultants
Anesthesiologi
sts

Diagnosis

Diagnosis

Disease	Disease Type
CEREBRAL VENOUS SINUS THROMBOSIS STATUS EPILEPTICUS	

C/o Weakness of left upper limb and lower limb, slurring of speech

ADMISSION VITALS:

PR-66/min

BP-100/60mmhg

RR-22/mmin

RS-BAE+

CVS-S1S2+

P/A-soft

SPO2-96%

A 16 years old male patient Mr. MARUTHI REDDYGANI presented to ER with c/o weakness of left upper limb and lower limb, slurring of speech. All Investigations were done, CT brain

showed cerebral venous sinus thrombosis and suggestive of haemorrhagic venous infarct. Patient was started on antiepileptics and supportive treatment. In view of recurrent seizures patient was intubated on 16/06/2022 and connected to ventilator support. Throughout hospitalisation patient was on ventilator support. Patient was intubated and sedated, patient attenders were explained about the condition and the need of further hospitalisation. But patient attenders are unwilling, go to her other hospital. Hence patient is being discharged against medical advice. At the time of discharge patient is on mechanical ventilator support.

ARH1.0001232699

Name

Mr. DASARI
RAVI

Patient Identifier ARHIP56396

Age 34Yr
0Mth
15Days

Sex Male

Date of Admission 28-Jun-2022

Date of Discharge 30-Jun-2022
MLC No

Address RAJARAMPALLY,Telangana

Ward/Bed No First
Floor,
MICU,
Bed
no:MIC
U 2

Primary Consultant Dr Chandra Shekar
Sathineni(MD (Internal
Medicine))--INTERNAL
MEDICINE

Consultants

Surgeons

Anesthesiologists

☐ **Diagnosis**
S

Diagnosis

Disease	Disease Type
HERBICIDAL POISONING	Sec

Alleged history of consumption of herbicidal poison on 29/06/22 at 8.00 PM.
Initially treated outside hospital and came here for further management

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 34 years old male patient Mr. DASARI RAVI came with alleged history of consumption of herbicidal poison on 29/06/22 at 8.00 PM. Initially treated outside hospital and came here for further management. All necessary investigations were done and diagnosed as HERBICIDAL POISONING. Managed conservatively. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001220636

Name

Mrs. VASANTHA
SANGAM

**Patient
Identifier**

ARHIP56569

Age

75Yr
10Mth
14Days

Sex

Female

**Date of
Admission**

11-Jul-
2022

**Date of
Discharge
MLC No**

Address

H.NO:5-
15,THOTAPALLY,BEJJENKI,SIDDIPET,Other,Telanga
na

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 3

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

edit

CORONARY ARTERY DISEASE, AWM I

MILD LV SYSTOLIC DYSFUNCTION [50%]

CORONARY ANGIOGRAM (03/09/2021) -CAD-DVD

S/P PTCA+DES TO LCX, LAD DONE ON 03/09/2021

CORONARY ANGIOGRAM (13/07/2022)-CAD-DVD [LAD, RCA]

PLAN CABG WITH GRAFT TO LAD, RCA

C/o chest pain since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 75 years old female patient Mrs. VASANTHA SANGAM came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, MILD LV SYSTOLIC DYSFUNCTION [50%], CORONARY ANGIOGRAM (03/09/2021) -CAD-DVD, S/P PTCA+DES TO LCX, LAD DONE ON 03/09/2021, CORONARY ANGIOGRAM (13/07/2022)-CAD-DVD [LAD, RCA], PLAN CABG WITH GRAFT TO LAD, RCA. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RECLIDE-XR 30 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. BETALOC 25 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. TAB. PANTOCID 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

APOCUS

ARH1.0001232607

Name

Mr.
KUNDARAPU
SADANANDA
M

Patient
Identifier

ARHIP56357

Age

48Yr
0Mth
18Days

Sex

Male

Date of
Admission

26-Jun-
2022

Date of
Discharge

12-Jul-2022

MLC No

Address

17-1-44, rajeevnagar,
Godavarikhani,
maredupaka,Karimnagar,Telang
ana

Ward/Bed No

First
Floor,
SICU,
Bed
no:SICU
6

Primary
Consultant

DR. SUBRAT KUMAR SOREN --
NEUROSURGERY

Consultants

Surgeons

Anesthesiologi
sts

Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
	Pd

RTA- TRAUMATIC BRAIN INJURY.
BASIFRONTAL CONTUSIONS

DIFFUSE AXONAL INJURY [GRADE-II]

MAXILLO FACIAL INJURY

ACUTE DELIRIUM TREMENS

ALCOHOL WITHDRAWAL SYNDROME

Alleged history of RTA 2 wheeler vs 4 wheeler at 2 pm at godhavarikani on 26. 06. 2022. patient presented with altered sensorium, history history of left ear bleed above right eye.

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+

SPO2-96%

A 48 years old male patient Mr. KUNDARAPU SADANANDAM presented to ER with Alleged history of RTA 2wheeler vs 4wheeler at 2 PM at godhavarikani on 26.06.2022. Patient presented with altered sensorium with history of left ear bleed. All necessary investigations were done and diagnosed as RTA- TRAUMATIC BRAIN INJURY, BASIFRONTAL CONTUSIONS, DIFFUSE AXONAL INJURY [GRADE-II], MAXILLO FACIAL INJURY, ACUTE DELIRIUM TREMENS, ALCOHOL WITHDRAWAL SYNDROME. Patient was treated conservatively. Dermatologist consultation taken advised followed. Patient improved symptomatically and needs further de-addiction and rehabilitation. He is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. BREVIPIL 50MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. AXOZAP (OXEZEPAM) 15 MG TWICE DAILY AT 8AM AND 8PM 30 DAYS
3. TAB. QUITIPIN 25MG. TWICE DAILY AT 8AM AND 8PM 10` DAYS
4. TAB. BENFOMET PLUS ONCE DAILY AT 2PM FOR 10 DAYS.
5. PATCH 2 BACONYL 14 MG ONCE DAILY AT 8AM FOR 10 DAYS.
6. TAB. PANTOP 40MG ONCE DAILY AT 8AM FOR 10 DAYS
7. TAB. AVIL 25MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
8. TAB. LEVOCETIRIZINE 5 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
9. SYP. LACTIFIBER 15ML ONCE DAILY AT BED TIME FOR 2-3 DAYS
10. LOTION LULIFIN LOCAL APPLYING THRICE DAILY
11. KETO SOAP BATH DAILY
12. TAB. ROXSAFE 500MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.

REVIEW AFTER 10 DAYS TO NEURO SURGEON OPD.

ARH1.0001155295

Name

Mr.
PASHAM
RAMULU

Patient Identifier

ARHIP56567

Age

64Yr
1Mth
24Days

Sex

Male

**Date of
Admission**

11-Jul-
2022

**Date of Discharge
MLC No**

Address

mallapur,thimmapur,Karimnagar,Telangan
a

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
9

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

SYNCOPE FOR EVALUATION

DYSELECTROLYTEMIA

HYPOKALAEMIA CORRECTED (S.K+ 2.7 on 11/07/2022 to 4.2 improved on 14/07/2022)

OLD DIAGNOSIS: CAD, OLD PWMI

S/P PTCA TO LCX IN 2018

S/P CORONARY ANGIOGRAM DONE ON 13/07/222 CAD - DVD (LAD, PROXIMAL ISR IN LCX STENT)

PLAN MEDICAL MANAGEMENT

C/o sudden fall from chair associated with loss of consciousness (5 minutes)

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 64 years old male patient Mr. PASHAM RAMULU came with c/o sudden fall from chair associated with loss of consciousness (5 minutes). All necessary investigations were done and diagnosed as SYNCOPES FOR EVALUATION, DYSELECTROLYTEMIC, HYPOKALAEMIA CORRECTED (S.K+ 2.7 on 11/07/2022 improved to 4.2 on 14/07/2022), OLD DIAGNOSIS: CAD, OLD PWMI, S/P PTCA TO LCX IN 2018, S/P CORONARY ANGIOGRAM DONE ON 13/07/22 CAD - DVD (LAD, PROXIMAL ISR IN LCX STENT). Patient and patient attenders were explained about medical management and stent to diagonal (thin vessel.) Patient attenders are willing for medical management. Hence patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET-A 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. PROLOMET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. CARDACE 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RANTAC 150MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 11 DAYS.
6. LIFESTYLE MODIFICATIONS FOR DIABETES

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233186

	Name		Mr. MOHAMMED ATHIK	
Patient Identifier	ARHIP56580	Age	38Yr 0Mth 3Days	
Sex	Male	Date of Admission	12-Jul-2022	
Date of Discharge MLC No				
Address	H.NO:9-65,MAHADEVPOOR,BHUPALAPALLY,Other,Telangana		Ward/ Bed No	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE , IWMI

MODERATE LV DYSFUNCTION, EF-38%, SR

S/P CORONARY ANGIOGRAM DONE ON 13/07/2022 - CAD-TVD [LAD, LCX, RCA]

PLAN CABG.

C/o left sided chest pain, radiating to the back a since 3-4 days

At Admission

Afebrile

PR: 86/min

BP: 110/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-99%

A 38 years old male patient Mr. MOHAMMED ATHIK came with c/o left sided chest pain, radiating to the back a since 3-4 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , IWMI, MODERATE LV DYSFUNCTION, EF-38%, SR, S/P CORONARY ANGIOGRAM DONE ON 13/07/2022 – CAD-TVD [LAD, LCX, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 50 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
5. CAP. ANGISPAN TR 2.5 MG TWICE DAILY AT 8AM, 8PM TO CONTINUE.
6. TAB. FRUSELAC ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

ARH1.0001232975

		Mr. GANGAMALLAIAH KUDUKALA	
Name			
Patient Identifier	ARHIP56502	Age	58Yr 0Mth 6Days
Sex	Male	Date of Admission	06-Jul-2022
Expired Date	12-Jul-2022		
MLC No			
Address	6-70/01 ARPALLY,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 12
Primary Consultant	DR. SANJAY KUMAR KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY	Consultants	
Surgeons		Anesthesiologists	



Cause of Death

Cause of Death



Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

LARGE ACUTE RIGHT MCA TERRITORY INFRACT
K/C/O:HTN,TYPE II DM.

C/o giddiness since 1 day
1-2 episodes of syncopal attack
Left sided facial deviation

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 58 years old male patient Mr. GANGAMALLAIAH KUDUKALA presented to ER with c/o giddiness since 1 day, 1-2 episodes of syncopal attack, left sided facial deviation. All necessary investigations were done and diagnosed as LARGE ACUTE RIGHT MCA TERRITORY INFRACT, K/C/O:HTN,TYPE II DM. On 11.07.2022 patient was developed bradycardia, patient was intubated and connected mechanical ventilator . On 12.07.2022 at 6.00 AM patient was unresponsive, CPR was initiated as per ACLS protocols, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 06.39 AM on 12/07/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO LARGE ACUTE RIGHT MCA TERRITORY INFRACT

ARH1.0001232666

Name

Mr. SRINIVAS CH

Patient Identifier

ARHIP56596

Age

57Yr
0Mth
17Days

Sex

Male

Date of Admission

13-Jul-2022

**Date of Discharge
MLC No**

Address

7-1-243
MANKAMATHOTHA,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no:SICU
3

Primary Consultant

DR. SUBRAT KUMAR SOREN

RTA WITH POST-TRAUMATIC BRAIN INJURY LARGE PCA STROKE

C/o altered sensorium since 2 days, weakness of right upper limb and lower limb
Incontinence of bladder since 2 days

History of trauma (RTA 15 days back)

Known case of hypertension, diabetes mellitus

AT ADMISSION:

Afebrile

PR: 125/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 57-year-old male patient SRINIVAS presented with c/o altered sensorium since 2 days, weakness of right upper limb and lower limb, Incontinence of bladder since 2 days, History of trauma (RTA 15 days back), Known case of hypertension, diabetes mellitus. All necessary investigations were done and diagnosed as RTA WITH POST-TRAUMATIC BRAIN INJURY , LARGE PCA STROKE. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient is being discharged under LAMA

ARH1.0001231792

Name

Mrs. MEDAM
SUNITHA

Patient Identifier

ARHIP56261

Age

39Yr 1Mth
9Days

Sex

Female

**Date of
Admission**

21-Jun-
2022

Date of Discharge

21-Jun-2022

MLC No

Address

q no : sd-27,naspur
colony,,Mancherial,Telangana

Ward/Bed No

Ground
Floor,
Emergency
Ward,
Bed
no:EME2

Primary Consultant

DR. SRI KARAN UDDESH --INTERNAL
MEDICINE

Surgeons

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
---------	--------------

ACUTE EXACERBATION OF BRONCHIAL ASTHMA WITH SEPTICK SHOCK.

C/o progressive dyspnoea , body ache since 7 days

Known case of bronchial asthma

AT ADMISSION:

PR: 81/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 39-year-old female patient Mrs. MEDAM SUNITHA presented with above-mentioned complaints as patient was drowsy and ABG revealed type-II respiratory acidosis. Patient was intubated and connected to mechanical ventilator. Patient was started on broad spectrum antibiotics, ionotropic support in view of hypotension the patient is currently on mechanical ventilation and requires further management, patient attendants are unwilling, hence patient is discharged against medical advice.

ARH1.0001233134

Name

Mr. THARUN K

Patient Identifier

ARHIP56553

Age

20Yr
0Mth
2Days

Sex

Male

Date of Admission

10-Jul-2022

Expired Date

12-Jul-2022

MLC No

Address

ANTHARGAM,
JAGITIAL,Karimnagar,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MICU
2

Primary Consultant

Dr. RAMCHANDER
TORREM(DM(NEPHROLOGY)
(NIMS),RENAL TRANSPLANT PHYSICIAN)--
NEPHROLOGY

Consultants

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
.	

PARAQUAT POISONING

Alleged history of consumption of **paraquat** pesticide of unknown quantity on 10/07/22, Initially treated at local hospital and came here for further management

AT ADMISSION:

PR: 18/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 20 years old male patient Mr. THARUN came with Alleged history of consumption of **paraquat** pesticide of unknown quantity on 10/07/22, Initially treated at local hospital and came here for further management. All necessary investigations were done and diagnosed as PARAQUAT POISONING. Poor prognosis explained to the patient attendants, suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.27 AM on 12/07/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO ACUTE RESPIRATORY DISTRESS SYNDROME,
PARAQUAT POISONING .

ARH1.0001233073

Name

Mr. K RAMA
KRISHNA

**Patient
Identifier**

ARHIP56526

Age

49Yr
0Mth
9Days

Sex

Male

**Date of
Admission**

07-Jul-
2022

**Date of
Discharge
MLC No**

Address

Dasturabad, Nirmal, Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 8

**Primary
Consultant**

DR. SANJAY KUMAR
KAMINWAR

ACUTE B/L PCA TERRITORY INFARCT

C/o left sided weakness a/w vomiting since 2 days

K/c/o HTN, T2DM

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 49 years old male patient K. RAMA KRISHNA came with c/o left sided weakness a/w vomiting since 2 days. All necessary investigations were done and diagnosed as ACUTE B/L PCA TERRITORY INFARCT. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. PREVA AS 75 MG ONCE DAILY AT 2PM FOR 10 DAYS.
2. TAB. ATOCOR 40MG ONCE DAILY AT 8PM FOR 10 DAYS.
3. TAB. TELVAS 40MG ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. MODALERT 100MG ONCE DAILY AT 8AM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN DR. SANJAYKUMAR sir OPD.

ARH1.0001233
317

Name

Mrs.
CHILUVER
I LAXMI

**Patient
Identifier** ARHIP56639

Age 48Yr
0Mth
0Days

Sex Female

**Date of
Admission** 16-Jul-
2022

**Date of
Discharge**
MLC No

Address 4-
80,godishalapeta,velgatur,jagtial,Karimnagar
,Telangana

**Ward/
Bed No** First
Floor,
CICU ,
Bed
no:CICU1
0

**Primary
Consultant
Surgeons** Dr. Vidya Sagar A--CARDIOLOGY

Consultants

ANAPHYLACTIC SHOCK
DENOVA T2DM
ACUTE KIDNEY INJURY
HYPOKALAEMIA
DCMP, LBBB, SR, MODERATE LV DYSFUNCTION [EF-35%]
CAG (17/06/2022) (NIMS) - NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o sudden syncopal attack at home on 15/07/2022 at around 6.30 PM

H/o fever since 2 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 80/50mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 48 years old female patient Mrs. CHILUVERI LAXMI came with c/o sudden syncopal attack at home on 15/07/2022 at around 6.30 PM. All necessary investigations were done and diagnosed as ANAPHYLACTIC SHOCK, DENOVA T2DM, ACUTE KIDNEY INJURY , HYPOKALAEMIA , DCMP, LBBB, SR, MODERATE LV DYSFUNCTION [EF-35%]. CAG (17/06/2022) (NIMS) - NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CARDIVAS 3.125 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ISOLAZINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ALDACTONE 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. OXRAMET XR 10/500 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. CETZINE 10 MG ONCE DAILY AT 8PM FOR 5 DAYS
7. TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE BEFORE BREAKFAST.
8. SYP. POTKLOR 15 ML ½ GLASS OF WATER THRICE DAILY AT 8AM 2PM 8PM

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH RP-II, FBS/PLBS REPORTS

ARH1.0001219310

Name

Mr. ODELU
BANDARI

Patient Identifier

ARHIP56557

Age

61Yr
11Mth
6Days

Sex

Male

**Date of
Admission**

10-Jul-
2022

**Date of Discharge
MLC No**

Address

H.NO:14-4-506,VITAL
NAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

MILD LV DYSFUNCTION [EF-45%]

R/F : ALCOHOLIC

CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 43 years old male patient G. RAJU came with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MILD LV DYSFUNCTION [EF-45%], R/F : ALCOHOLIC, CORONARY ANGIOGRAM (21/12/2021) -CAD-RCA mid moderate stenosis

PLAN MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB: CARDACE-H 2.5MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001219310

Patient Identifier ARHIP56557

Sex Male

Date of Discharge
MLC No

Address H.NO:14-4-506,VITAL
NAGAR,GODHAVARIKHANI,PEDDAPALLY,Other,Telanga
na

Primary Consultant Dr. Vidya Sagar A--CARDIOLOGY

Name Mr. ODELU
BANDARI

Age 61Yr
11Mth
6Days

Date of Admission 10-Jul-
2022

Ward/ Bed No First
Floor,
CICU ,
Bed
no:CICU1
3

ACUTE DECOMPENSATED HEART FAILURE (ADVANCED H F)
ISCHAEMIC CARDIOMYOPATHY
SEVERE LV DYSFUNCTION (EF 30%)
CAD - S/P CABG (2017)
EXTERNAL HAEMORRHOIDECTOMY (20/08/21)
DEBRIDEMENT WITH CYSTOSCOPY (20/01/22)
KNOWN CASE OF ADHF
R/F: HYPERTENSION, T2 DIABETES MELLITUS

C/o Shortness of breath grade- IV
Chest pain and abdominal discomfort
Bilateral pedal oedema
Decreased urine output

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 61 years old male patient Mr. ODELU BANDARI came with c/o shortness of breath grade- IV, Chest pain and abdominal discomfort, bilateral pedal oedema, increased frequency of urine micturition. All necessary investigations were done and diagnosed as ACUTE DECOMPENSATED HEART FAILURE (ADVANCED HF), ISCHAEMIC CARDIOMYOPATHY, SEVERE LV DYSFUNCTION (EF 30%), CAD - S/P CABG (2017), EXTERNAL HAEMORRHOIDECTOMY (20/08/21) ,DEBRIDEMENT WITH CYSTOSCOPY (20/01/22), KNOWN CASE OF ADHF. Pulmonologist and Urologist consultations done and treated accordingly. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. CARDIVAS 3.125MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. CIDMUS 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. DAPAGLYN 10 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
9. TAB. VOGS 0.2 MG THRICE DAILY AT 8AM 2PM 8PM BEFORE FOOD TO CONTINUE.
10. TAB. URIMAX 0.4 MG ONCE DAILY AT 8PM FOR 21 DAYS.
11. TAB. AZEE 500 MG ONCE DAILY AT 2PM FOR 1 DAY - 1 TAB.
12. FORECORT 200 MG INHALER **TWICE IN A DAY AT 8 AM 8 PM** FOR 15 DAYS.
13. TAB. DOLO 650 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
14. TAB. TORQ-SR 4 MG ONCE DAILY AT 2PM FOR 21 DAYS.
15. SYP. ALKAPAC 10 ml THRICE DAILY AT 8AM 2PM 8PM

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001216323

Name		Mr. NARAYANA GOUD KISARI	
Patient Identifier	ARHIP56608	Age	71Yr 0Mth 9Days
Sex	Male	Date of Admission	13-Jul-2022
Date of Discharge			
MLC No			
Address	H.NO:5-1,GOLETI TOWNSHIP,REBBENA,KOMURAMBHEEM ASIFABAD,Other,Telangana		
Primary Consultant	Dr. KRISHNA CHAITANYA	Ward/ Bed No	First Floor, SICU, Bed no:SICU 1

CAD-UNSTABLE ANGINA

CORONARY ANGIOGRAM (15/07/2022) -NORMAL CORONARIES

C/o chest pain since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 71 years old male patient Mr. NARAYANA GOUD KISARI came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CAD-UNSTABLE ANGINA, CORONARY ANGIOGRAM (15/07/2022) -NORMAL CORONARIES. Managed conservatively. General Physician consultation taken and advice followed. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN -AV 75/10 ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. DOPAFY 10 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233236

Name

Mr.
KANNURI
POCHAIH

Patient Identifier ARHIP56604

Age 60Yr
0Mth
3Days

Sex Male

Date of Admission 13-Jul-2022

Date of Discharge
MLC No

Address manthani,Ramagundam,Telangan

Ward/Bed No First Floor, SICU, Bed no:SICU 2

Primary Consultant Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE, NSTEMI

CORONARY ANGIOGRAM (15/07/2022) -Diagonal ostial 70% stenosis

RCA-PDA, PLV- ECTATIC SLOW FLOW

MINOR CAD + ECTATIC CORONARIES - SLOW FLOW

C/o shortness of breath, grade-2 since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 84/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 60 years old male patient Mr. KANNURI POCHAIH came with c/o shortness of breath, grade-2 since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, CORONARY ANGIOGRAM (15/07/2022) - Diagonal ostial 70% stenosis, RCA-PDA, PLV- ECTATIC SLOW FLOW, MINOR CAD + ECTATIC CORONARIES - SLOW FLOW. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ROXSAFE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ECOSPRIN AV ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. AMLODAC 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

56600

ARH1.0001232361	Name	Mr. MARAM REDDY SLIVA REDDY .
Patient Identifier	ARHIP56600	Age 71Yr 0Mth 29Days
Sex	Male	Date of Admission 13-Jul-2022
Date of Discharge MLC No		
Address	8-7-179/1, KOTHIRAMPUR,,Karimnagar,Telangana	Ward/ Bed No First Floor, CICU , Bed no:CICU1 1
Primary Consultant	Dr. KRISHNA CHAITANYA	

VALVULAR HEART DISEASE,
SEVERE AORTIC STENOSIS,
SEVERE LV DYSFUNCTION,
LVEF-35%, HF, SR,
NOW S/P TRANSCATHETER AORTIC VALVE IMPLANTATION
(14/07/2022)
S/P PTCA TO RCA (14/07/2022),
LBBB PROGRESSED TO COMPLETE HEART BLOCK S/P DDDR
(16/07/2022),
UPPER RESPIRATORY TRACT INFECTION.NO HF.

C/o breathlessness since 1 month

AT ADMISSION:

Afebrile

PR: 84/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 71 years old male patient Mr. MARAM REDDY SLIVA REDDY came with c/o breathlessness since 1 month. Now, admitted for transcatheter heart valve implantation.

Course in the hospital:

Mr. Sliva Reddy M, 71 year old male presented to hospital with history of breathlessness 1 month back. On evaluation diagnosed to have severe Aortic stenosis with severe LV dysfunction, FC IV Dyspnea.

He was stabilized with medications, options of valve replacement were discussed with family as 1 year mortality in Severe AS patients with severe LV dysfunction is very high. As he is a high surgical risk candidate for Open heart surgery and tolerating heart-lung bypass, options of TAVI as well as surgery were discussed. Also advised for multiple opinions at other Cardiac centers.

Family members & Mr. Sliva reddy decided for minimally invasive TAVI procedure. All risks involved in this procedure including mortality were explained. Higher risk than normal for Coronary obstruction and risk of development of Complete Heart Block during (or) post-operatively were also explained.

After informed consent, under General anaesthesia with Aseptic precautions, Balloon occlusive Aortic root angiography done showed slow filling of Right coronary artery. Hence with a JR guide and a Catheter extending to RCA ostium. 3 x 24 mm RCA stent positioned in mid RCA for right coronary protection.

26 mm MVVAL Transcatheter Heart valve positioned across Aortic annulus and implanted at a depth of 4 mm below the

annulus. Aortic Root injection showed mild compromise of RCA ostium as longer leaflet of bicuspid valve is abutting it. Hence, RCA was stented from proximal RCA in to Aorta, good TIMI-III flow. No significant Aortic Regurgitation (or) Para valvular Leak No gradients across Aortic valve.

Patient developed LBBB intraprocedurally. Hence, Temporary Pacemaker kept in situ. After 24 hrs, Patient was in Sinus Rhythm with LBBB. Hence TPI Removed. Later same day, he progressed to complete Hear Block hence, TPI repositioned. After discussing with family, DDDR permanent pacemaker Implantation done. Good result. Parameters were normal. He was monitored for infection, hemodynamics and symptoms.

He has mild upper respiratory tract symptoms of cough with mucoid expectoration. He was continued on antibiotics. He was symptomatically better and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ACEBROPHYLLINE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. FRUSELAC DS (40/60) **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
4. TAB. MONTEK LC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
6. SYP. ASCORIL-LS QID
7. SYP. CREMAFFIN 10 ML ONCE DAILY AT 8PM
8. SYP. POTKLOR 15 ml ONCE DAILY AT 8PM
- 9.
- 10.TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 11.TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 12.TAB. IVABRAD 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 13.TAB. ROSUVAS 20 MG ONCE DAILY AT 8PM TO CONTINUE.
- 14.TAB. FAROPENEM 200 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 1 WEEK.

REVIEW AFTER 5 DAYS TO CARDIAC OPD FOR WOUND DRESSING

RAYAMALLU %%%%%%%%%56417

Patient was taken over from Urology on 05/07/ 2022 after patient had undergone TURP and optical urethrotomy. Patient was drowsy was in hypotension and was diagnosed to have sepsis with multiorgan dysfunction syndrome. Patient was started on INJ. MEROPENEM according to creatinine clearance blood cultures and urine cultures were sent. Patient was intubated in view of poor GCS. Blood culture was sterile urine culture showed growth and antibiotics were adjusted according to sensitivity. Patient continued to require mechanical ventilation. Patient recovered from hypotension and acute kidney injury. Despite broad spectrum antibiotics patient continued to have fever spikes . Patient was extubated on 13/07 /22. Was maintaining saturation of 3 L/min of oxygen.

On 14/07/22 in the night patient's GCS drop to 3 / 15 and he had paucity of limb movements an MRI brain revealed posterior circulation infarcts. A Neurologist consultation was taken and advice was followed patient was re intubated in view of poor GCS. Patients urine output decreased nephrology consultation was taken and 2 cycles of/dialysis were done. Patient's condition did not improve with the above treatment interventions. On 20/07/2022 patient had sudden cardiac arrest at so and so time CPR was initiated according to ACLS protocol despite best efforts patient could not be revived and declared dead at so and so time.

ARH1.0001233491

Name

Mr. AHMED PASHA

Patient Identifier

ARHIP56709

Age

32Yr
0Mth
1Days

Sex

Male

Date of Admission

20-Jul-2022

**Date of Discharge
MLC No**

Address

NTPC GODAVARIKHANI
PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no: SICU
6

Primary Consultant

DR. SUBRAT KUMAR SOREN

RTA POLYTRAUMA
TRAUMATIC BRAIN INJURY
ACUTE SUBARACHNOID HAEMORRHAGE (SAH)
ACUTE SUBDURAL HAEMORRHAGE (SDH)
LEFT ORBITAL WALL FRACTURE AND HAEMATOMA
LEFT HUMERUS FRACTURE
LEFT PELVIC DISLOCATION
LEFT FRONTAL BONE DEPRESSED FRACTURE
MAXILLOFACIAL INJURY

Patient alleged history of RTA following which he sustained injury over head, maxilla-facial, left hand, left leg,

H/o ENT bleed

AT ADMISSION:

Patient drowsy

Afebrile

PR: 110/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 11/min

SPO2: 98% on room air

P/A: Soft, BS+

A 32 years old male patient Mr. AHMED PASHA came with alleged history of RTA following which he sustained injury over head, maxilla-facial, left hand, left leg, H/o ENT bleed. All necessary investigations were done and diagnosed as RTA POLYTRAUMA, TRAUMATIC BRAIN INJURY, ACUTE SUBARACHNOID HAEMORRHAGE (SAH), ACUTE SUBDURAL HAEMORRHAGE (SDH), LEFT ORBITAL WALL FRACTURE AND HAEMATOMA, LEFT HUMERUS FRACTURE
LEFT PELVIC DISLOCATION, LEFT FRONTAL BONE DEPRESSED FRACTURE,
MAXILLOFACIAL INJURY. Managed accordingly. Patient condition and need for further hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA

ARH1.0001233221

Name

Mr. K
DAMODHAR

Patient Identifier

ARHIP56606

Age

62Yr
0Mth
7Days

Sex

Male

**Date of
Admission**

13-Jul-
2022

**Date of Discharge
MLC No**

Address

vallampahad,,Karimnagar,Telangana

**Ward/Bed
No**

Second
Floor,
Semi
Private
, Bed
no:122
A

Primary Consultant

Dr. SURESH GOUD

LEFT PYELONEPHRITIS + UROSEPSIS

SURGERY : LEFT DJ STENTING DONE ON 15.07.2022

C/o abdominal pain a/w fever since few days

K/c/o HTN, T2DM, Bronchial Asthma

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 62 yrs old male patient Mr. DAMODHAR came to the hospital with c/o abdominal pain a/w fever since few days. All necessary investigations done and diagnosed as LEFT PYELONEPHRITIS + UROSEPSIS, SURGERY : LEFT DJ STENTING DONE ON 15.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: FAROBACT 200 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 11DAYS.
5. TAB: VELTAM 0.4 MG ONCE DAILY AT 8PM FOR 11DAYS.
6. SYP. K-CIT 10 ml TWICE DAILY AT 8AM 8PM FOR 10DAYS.

REVIEW AFTER 7 DAYS TO UROLOGY OPD

ARH1.0001233245

Name	Mrs. RADHAMMA MUKKE		
Patient Identifier	ARHIP56610	Age	60Yr 10Mth 12Days
Sex	Female	Date of Admission	14-Jul-2022
Date of Discharge			
MLC No			
Address	VADAKAPURAM,Karimnagar,Telangana	Ward/ Bed No	Second Floor, Semi Private, Bed no:120 A
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY		

RIGHT URETERIC CALCULUS
SURGERY: RIGHT URSL+DJ STENTING DONE ON 15.07.2022

C/o right loin pain, burning micturition since 7 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 60 yrs old female patient Mrs. RADHAMMA MUKKE came to the hospital with c/o right loin pain, burning micturition since 7 days. All necessary investigations done and diagnosed as RIGHT URETERIC CALCULUS, SURGERY: RIGHT URSL+DJ STENTING DONE ON 15.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM, FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS
5. TAB: VELTAM 0.4 MG ONCE DAILY AT 8PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001172921

	Name	Mrs. RAMADEVI B		
Patient Identifier	ARHIP56543	Age	48Yr 4Mth 12Days	
Sex	Female	Date of Admission	09-Jul-2022	
Date of Discharge				
MLC No				
Address	CARMAS COLONY,KTK-1 INCLAIN,BHOOPALAPALLY,,Warangal,Telangana		Ward/ Bed No	Second Floor, Semi Private , Bed no:103B
Primary Consultant	Dr Chandra Shekar Sathineni			

BULLOUS PEMPHIGOID

C/o pain lower lips and tongue since 4 days

Known case of bullous pemphigoid since 4 years

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 48 years old female patient Mrs. RAMADEVI came with c/o pain lower lips and tongue since 4 days. Known case of bullous pemphigoid since 4 years. All necessary investigations were done and diagnosed as BULLOUS PEMPHIGOID. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. AZIRON 500 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. PANTOCID-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. HEDNEURON ONCE DAILY AT 2PM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233358

Name

Mr.
BEERAIAH
EERI

Patient Identifier

ARHIP56659

Age 58Yr 0Mth
4Days

Sex

Male

Date of Admission 17-Jul-2022

Date of Discharge

MLC No

Address

H.NO:3-
41,GUNDARAM,BEJJENKI,SIDDIPET,Other,Telanga
na

**Ward/
Bed No**

First Floor,
RECOVERY
ROOM, Bed
no:RR 2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWM

SEVERE LV DYSFUNCTION, [EF-30%], SR

S/P CORONARY ANGIOGRAM DONE ON 19/07/2022 - CAD-TVD [LAD, LCX, RCA]

PLAN CABG.

R/F: T2DM

C/o Retrosternal chest pain, radiating to the back since 2 days

At Admission

Afebrile

PR: 74/min

BP: 100/70 mmHg

RR-16/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 58 years old male patient Mr. BEERAAIAH EERI came with c/o retrosternal chest pain, radiating to the back since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWTMI, SEVERE LV DYSFUNCTION, [EF-30%], SR, S/P CORONARY ANGIOGRAM DONE ON 19/07/2022 – CAD-TVD [LAD, LCX, RCA], PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
5. TAB. DAPHAGLYN 10 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. ALDACTONE 25 MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. URIMAX 0.4 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001233325

Name

Mrs.
RAJAMMA
PILLI

Patient Identifier

ARHIP56642

Age

78Yr
6Mth
4Days

Sex

Female

**Date of
Admission**

16-Jul-
2022

**Date of Discharge
MLC No**

Address

1-33,
POCHAMPALLI,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no:SICU
5

Primary Consultant

Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE, EXTENSIVE AWMi-STEMI
SEVERE LV DYSFUNCTION,
KILLIP CLASS-III
CARDIOGENIC SHOCK
LM+TVD

C/o chest pain, breathing difficulty since 2 days

AT ADMISSION:

Afebrile

PR: 84/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft

A 78 years old female patient Mrs. RAJAMMA PILLI presented with c/o chest pain, breathing difficulty in Pulmonary oedema and cardiogenic shock. She was stabilised with IV medications and NIV. CAG done showed LM +TVD, not suitable for PTCA. She was optimised with medication, options of CABG and medical therapy were offered. Poor prognosis explained to family.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. MET-XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM** 8AM TO CONTINUE.
- 6) TAB. DYTOR PLUS 10 MG 1 TAB AT 8AM, ½ TAB TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001233390

Name

Mr. DASARI
RAJ KUMAR

**Patient
Identifier**

ARHIP56672

Age

47Yr
0Mth
2Days

Sex

Male

**Date of
Admission**

18-Jul-
2022

**Date of
Discharge
MLC No**

Address

RAMAGUNDAM,
PEDDAPALLY,Ramagundam,Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private,
Bed
no:122
B

**Primary
Consultant**

DR. SRI KARAN UDDESH

CHRONIC LIVER DISEASE SECONDARY TO ETHANOL

C/o Decreased appetite

Numbness in the upper and lower limbs

H/o fever on and off since 1 year

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 96%

P/A: Soft, BS+

A 47 years old male patient Mr. DASARI RAJ KUMAR came with above mentioned complaints. Patient diagnosed as CHRONIC LIVER DISEASE SECONDARY TO ALCOHOL. Patient was treated with Inj Thiamine, Inj Neurit plus, Inj Pan and other supportive medications. Patient's condition improved, hence patient is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

ADV: UGI scopy to be done

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001233234		Name	Mrs. J ANASUYA
Patient Identifier	ARHIP56602	Age	86Yr 0Mth 7Days
Sex	Female	Date of Admission	13-Jul-2022
Date of Discharge	20-Jul-2022		
MLC No			
Address	SANTHOSH NAGAR ,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MIC U 7
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	Consultants	
Surgeons		Anesthesiologists	

Diagnosis

Diagnosis

Disease	Disease Type
ASPIRATION PNEUMONIA HYPONATREMIA K/C/O:HTN.	

C/o Vomiting 3 episodes

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 86 years old female patient Mrs. J ANASUYA came with above mentioned complaints. Patient diagnosed as ACUTE SEVERE SYMPTOMATIC HYPONATRAEMIA (THYROID INDUCED), ASPIRATION PNEUMONIA. Patient was treated with broad spectrum antibiotics, antacids and other supportive medications. General Physician, Neuro Physician and Cardiologist consultations taken and advice followed. Patient's condition improved, hence patient is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 2) TAB. ECOSPRIN AV 75/10 ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. APIXABAN 2.5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. LEVOFLOX 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS
- 5) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL SURGERY OPD

Kanakamma 56611

GLIOBLASTOMA MULTIFORME
SEPSIS WITH MULTIPLE ORGAN DYSFUNCTION

H/o bleed for ryle's tube

AT ADMISSION:

Patient is drowsy

GCS-3/15

PR: 117/min

BP: 140/80mmHg

RS: BAE+, B/l Crackles

CVS: S1S2, tachycardia

RR: 28/min

SPO2: 98% on room air

P/A: Soft,

Glioblastoma multiforme [Brain Cancer]

A 73 years old female patient Mrs. KANAKAMMA came with above mentioned complaints. The patient is a known case of glioblastoma multiforme, now presented with features of sepsis with multiple organ dysfunction. Patient's treatment was conservative in nature as attenders did not want active intervention in view of glioblastoma multiforme. Patient had UGI bleed so patient was started on INJ. PAN 8 mg/hour infusion, patient was started on broad spectrum antibiotics despite the above treatment patient continued to have bleeding and fever spikes now the patient is in hypotension and in a gasping state. The nature of the illness and the expected outcome has been explained in detail to the attenders. They have opted for End of life care and did not want any active intervention so the patient is being discharged against medical advice

ARH1.0001233342

	Name	Mr. YELLA MURTHI JITTAVENI		
Patient Identifier	ARHIP56647	Age	39Yr 6Mth 4Days	
Sex	Male	Date of Admission	16-Jul-2022	
Date of Discharge				
MLC No				
Address	1-67, CHINTAKUNTA,Karimnagar,Telangana		Ward/Bed No	Second Floor, Male General Ward, Bed no:GW19
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CORONARY ARTERY DISEASE, UNSTABLE ANGINA WITH ECG CHANGES
MILD LV DYSFUNCTION [EF-50%], SR

CORONARY ANGIOGRAM (20/07/2022) -CAD- mild disease (RCA)

PLAN MEDICAL MANAGEMENT

R/F : HTN

C/o chest pain since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 73/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 39 years old male patient Mr. YELLA MURTHI JITTAVENI came with c/o chest pain since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA WITH ECG CHANGES, MILD LV DYSFUNCTION [EF-50%], SR, CORONARY ANGIOGRAM (20/07/2022) - CAD- mild disease (RCA), PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. TAZLOC BETA 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. CTD 6.25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233184		Name	Mr. NAGARAJU BONALA
Patient Identifier	ARHIP56577	Age	37Yr 0Mth 9Days
Sex	Male	Date of Admission	11-Jul-2022
Date of Discharge			
MLC No			
Address	8-4-87 SEETHANAGAR, Karimnagar, Telangana	Ward/ Bed No	Second Floor, Male General Ward, Bed no:GW 20
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

CVA WITH ACUTE INTRAPARENCHYMAL BLEED

C/o Sudden onset left sided weakness associated with slurring of speech

AT ADMISSION:

Afebrile

PR: 71/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 37 yrs old male patient Mr. NAGARAJU BONALA came with c/o Sudden onset left sided weakness associated with slurring of speech . All necessary investigations done and diagnosed as CVA WITH ACUTE INTRAPARENCHYMAL BLEED. Managed conservatively. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. LEVIPIL 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 2) TAB. MODALERT 200MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO DR NIKHIL GOLI SIR OPD

ARH1.0001233085

	Name	Mr. RAJIREDDY VEMULA		
Patient Identifier	ARHIP56609	Age	57Yr 6Mth 18Days	
Sex	Male	Date of Admission	13-Jul-2022	
Date of Discharge MLC No				
Address	18-259 RAMAKRISHNA PUR,Karimnagar,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MIC U 4	
Primary Consultant	Dr Chandra Shekar Sathineni			

THROMBOCYTOPENIA FOR EVALUATION
MULTIPLE MYELOMA

C/o pain over back of neck radiating to trunk from 7days .

ON ADMISSION

Patient conscious, coherent

Afebrile

PR-80/min

BP- 140/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft, BS+
SPO2-99%

A 57years old male patient Mr. RAJIREDDY VEMULA presented to ER with. C/o pain over back of neck radiating to trunk from 7 days.All necessary investigations were done and diagnosed as THROMBOCYTOPENIA FOR EVALUATION, MULTIPLE MYELOMA . 1PCV AND 2RDP

transfusion done. Patient was treated conservatively. Patient condition explained patient attendants so getting discharge. And refer to higher center.

ARH1.0001233183

		Mrs. SHANTHAMMA J	
Patient Identifier	ARHIP56576	Age	73Yr 0Mth 9Days
Sex	Female	Date of Admission	11-Jul-2022
Date of Discharge MLC No			
Address	3-22, ROTI GUDA, JANNARAM,, Adilabad(Adilabad), Telangana	Ward/ Bed No	First Floor, MICU, Bed no: MIC U 6
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

ACUTE INFARCT IN LEFT MCA TERRITORY
THROMBOLIZED WITH INJ. TENECTEPLASE
HYPERNATREMIA
ACUTE KIDNEY INJURY

C/o sudden aphasia associated with right sided weakness

AT ADMISSION:

Patient is drowsy
PR: 90/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 73 years old female patient Mrs. SHANTHAMMA came with c/o sudden aphasia associated with right sided weakness . All necessary investigations were done and diagnosed as ACUTE INFARCT IN LEFT MCA TERRITORY, THROMBOLIZED WITH INJ. TENECTEPLASE, HYPERNATREMIA, ACUTE KIDNEY INJURY. Patient was thrombolized with INJ. TENECTEPLASE 8 mg at 9:00 a.m. on 11/07/22. Patient managed conservatively. Poor prognosis explained to patient attendants. They want to leave against medical advice, so patient is being discharged under LAMA.

ARH1.0001233380

Name

Mr.
LINGAIAH
GAJULA

Patient Identifier

ARHIP56668

Age

59Yr
0Mth
27Days

Sex

Male

**Date of
Admission**

18-Jul-
2022

**Date of Discharge
MLC No**

Address

3-65 SUNDILLA
PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
Bed
no:123
C

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, SR

MILD LV DYSFUNCTION, EF-50%

CORONARY ANGIOGRAM DONE ON 18/07/2022 - CAD- SVD (RCA)

S/P PTCA+DES TO RCA WITH 3.0 X 18 MM XIENCE XPEDITION DONE ON 18/07/2022.

C/o Retrosternal chest pain radiating to left arm associated with sweatings

AT ADMISSION:

Afebrile

PR: 73/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 59 years old male patient Mr. LINGAIAH GAJULA came with c/o retrosternal chest pain radiating to left arm associated with sweatings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AWTMI, SR, MILD LV DYSFUNCTION, EF-50%, CORONARY ANGIOGRAM DONE ON 18/07/2022 - CAD- SVD (RCA), S/P PTCA+DES TO RCA WITH 3.0 X 18 MM XIENCE XPEDITION DONE ON 18/07/2022. [LOT NO: 2011441, S/N :1070300-18]. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. NOVASTAT 40 MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. BETALOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.


WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001223510		Name	Mr. MADASU MALLESH
Patient Identifier	ARHIP56686	Age	71Yr 8Mth 19Days
Sex	Male	Date of Admission	18-Jul-2022
Date of Discharge			
MLC No			
Address	PALAKURTHI,Ramagundam,Telanga na	Ward/Bed No	First Floor, SICU, Bed no:SICU 6
Primary Consultant	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY	Consultants	
Surgeons	Dr. SURESH GOUD S(MS,M.Ch Urology(SVIMS),Consultant Urologist)--UROLOGY	Anesthesiologists	Dr Subba Reddy Kuppannagari-- ANAESTHESIOLOGY

 **Diagnosis**
S

Diagnosis

[Add
Diagnosis](#)

ARHIP56686

ARH1.000122351

☐ Surgery / Procedures
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
CYSTOSCOPY+, URETHRAL DILATATION				

BLADDER OUTFLOW OBSTRUCTION

SURGERY: CYSTOSCOPY+ URETHRAL DILATATION DONE ON 20.07.2022

C/o abdominal pain since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 66/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

All required investigations done and enclosed

A 71 yrs old male patient Mr. MADASU MALLESH came to the hospital with c/o abdominal pain since 1 week. All necessary investigations done and diagnosed as BLADDER OUTFLOW OBSTRUCTION, SURGERY: CYSTOSCOPY+URETHRAL DILATATION DONE ON 20.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: FAMOCID 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS TO UROLOGY OPD

ARH1.0001233415

Name

Mrs.
RODDA
LAXMI

Patient Identifier

ARHIP56689

Age 50Yr
0Mth
3Days

Sex

Female

Date of Admission 19-Jul-2022

**Date of Discharge
MLC No**

Address

PUTTAPAKA,Karimnagar,Telangana

**Ward/
Bed No** Second
Floor,
Semi
Private
, Bed
no:117
A

Primary Consultant

Dr Chandra Shekar Sathineni

ANAEMIA FOR EVALUATION
APD

C/o shortness of breath, generalised weakness and back pain

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 50 years old female patient Mrs. RODDA LAXMI came with c/o shortness of breath, generalised weakness and back pain. All necessary investigations were done and diagnosed as ANAEMIA FOR EVALUATION, APD. Managed conservatively. 4 Units PCV transfusions given. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1) TAB. LIMCEE TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

2) TAB. GEROZ-LP ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233291

Name

Ms. SRUTHI G

Patient Identifier

ARHIP56635

Age

30Yr
0Mth
6Days

Sex

Female

Date of Admission

15-Jul-2022

**Date of Discharge
MLC No**

Address

Other,Other

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:108
B

Primary Consultant

Dr. SURESH GOUD

LEFT RENAL CALCULUS

SURGERY : LEFT PCNL + DJ STENTING DONE ON 16.07.2022

C/o left loin pain, burning micturition since 10 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

All required investigations done and enclosed

A 30 yrs old female patient SRUTHI came to the hospital with c/o left loin pain, burning micturition since 10 days. All necessary investigations done and diagnosed as LEFT RENAL CALCULUS, SURGERY : LEFT PCNL + DJ STENTING DONE ON 16.07.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice. Patient explained for stent removal after 3 weeks.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 11DAYS.
5. SYP. K-CIT 10 ml THRICE DAILY AT 8AM, 2PM, 8PM FOR 10DAYS.

REVIEW AFTER 11 DAYS TO UROLOGY OPD, STENT REMOVAL AFTER 3 WEEKS

ARH1.0001233426

Name

Ms.
MAMATHA
A

Patient Identifier

ARHIP56682

Age

32Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

18-Jul-
2022

**Date of Discharge
MLC No**

Address

NTPC,
GODAVARIKANI, PEDDAPALLI, Karimnagar, Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:116
A

Primary Consultant

DR. SRI KARAN UDDESH

DENGUE FEVER WITH THROMBOCYTOPENIA
AKI [RESOLVED]
HEPATITIS [RESOLVING]

C/o fever since 4 days associated with vomiting, loose motions multiple episodes

AT ADMISSION:

PR: 74/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

Outside lab report: Dengue NS1 positive, platelets 30,000

A 32 years old female patient Ms. MAMATHA came with above mentioned complaints. Patient diagnosed as DENGUE FEVER WITH THROMBOCYTOPENIA, AKI [RESOLVED], HEPATITIS [RESOLVING]. Daily platelets monitoring done, patient had no bleeding manifestation during the hospital stay. Patient was treated with Inj Neurit plus, Inj Albumin and Inj Pan. Patient's condition improved, hence patient is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 7 DAYS

REVIEW AFTER 7 DAYS TO GENERAL MEDICINE OPD

ARH1.0001233450

Name

Mr.
CHEEKOTI
SHEKAR

Patient Identifier

ARHIP56700

Age

59Yr 0Mth
2Days

Sex

Male

Date of

Admission 19-Jul-2022
n

Date of Discharge

MLC No

Address

bhagath nagar,Karimnagar,Telangana

**Ward/
Bed No**

First Floor,
RECOVERY
ROOM, Bed
no:RR 8

Primary Consultant

Dr. SURESH GOUD

BPH WITH ? Ca PROSTATE

S/P: TRUS GUIDED PROSTATE BIOPSY DONE ON 20/07/2022

C/o difficulty in passing urine since 1 week

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 59 yrs old male patient Mr. CHEEKOTI SHEKAR came to the hospital with c/o difficulty in passing urine since 1 week. All necessary investigations done and diagnosed as BPH WITH ? Ca PROSTATE, S/P: TRUS GUIDED PROSTATE BIOPSY DONE ON 20/07/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: METROGYL TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
4. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
5. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS
6. TAB: VELTAM PLUS ONCE DAILY AT 8PM FOR 15 DAYS

REVIEW AFTER 7 DAYS TO UROLOGY OPD

ARH1.0001233318

Name

Mr. ANIL
KUMAR
KORRA

Patient Identifier

ARHIP56640

Age

40Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

16-Jul-
2022

**Date of Discharge
MLC No**

Address

7-89/1
CHEENUR,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 5

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE AWMI, SR
MODERATE LV DYSFUNCTION, EF-35%

S/P TLT WITH INJ. TENECTAPLASE 30 MG (OUTSIDE HOSPITAL) ON 15/07/2022

CORONARY ANGIOGRAM DONE ON 18/07/2022 - CAD- SVD (LAD)

S/P PTCA+DES TO D1 WITH 2.5 X 12 MM 3V ASTRA DONE ON 18/07/2022.

C/o Retrosternal chest pain radiating to left arm associated with sweatings

AT ADMISSION:

Afebrile

PR: 80/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 40 years old male patient Mr. ANIL KUMAR KORRA came with c/o retrosternal chest pain radiating to left arm associated with sweatings. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI, SR, MODERATE LV DYSFUNCTION, EF-35%, S/P TLT WITH INJ. TENECTAPLASE 30 MG (OUTSIDE HOSPITAL) ON 15/07/2022, CORONARY ANGIOGRAM DONE ON 18/07/2022 - CAD- SVD (LAD), S/P PTCA+DES TO D1 WITH 2.5 X 12 MM 3V ASTRA [LOT NO: 240225012, S/N :2202212019] DONE ON 18/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASITA 10 MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40 MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 50 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS
- 6) SYP. CREMAFFIN 2 tsp ONCE DAILY AT 8PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233367

Name

Mr. S RAJAM

Patient Identifier

ARHIP56661

Age

85Yr
0Mth
4Days

Sex

Male

Date of Admission

17-Jul-2022

**Date of Discharge
MLC No**

Address

Peddapalli
Manthani, Karimnagar, Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no: MICU
2

**Primary Consultant
Surgeons**

Dr. RAMCHANDER
TORREM(DM(NEPHROLOGY)
(NIMS), RENAL TRANSPLANT PHYSICIAN)--
NEPHROLOGY

Consultants

ACUTE KIDNEY INJURY

C/o Mild cough and mild shortness of breath since 2 days

History of decreased power in limbs and slurring of speech since 15 days

AT ADMISSION:

Afebrile

PR: 96/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 94% on room air

P/A: Soft

A 85 years old male patient RAJAM came with c/o Mild cough and mild shortness of breath since 2 days, History of decreased power in limbs and slurring of speech since 15 days. All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY. Managed conservatively. Neurophysician consultation taken, Cardiologist consultation taken advice followed. Patient attendant requested for discharge, patient referred to higher center for further management.

ARH1.0001233331

Name

Mr. SHIVA RAM E

Patient Identifier

ARHIP56643

Age

32Yr
0Mth
5Days

Sex

Male

Date of Admission

16-Jul-2022

**Date of Discharge
MLC No**

Address

HUSNABAD,,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 10

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

CAD, AWSTEMI,
S/P PRIMARY PTCA TO LAD,
VERY EARLY STENT THROMBOSIS (< 24 HOURS) ? CAUSE.
REVASCULARISED WITH PTCA,
MILD LV DYSFUNCTION,
NO HF, SR,
MUST BE ON TICAGRELOR,
IN VIEW OF HIGH RISK OF STENT THROMBOSIS.

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 32 years old male patient SHIVA RAM came with c/o chest pain, diagnosed as AWSTEMI. He was immediately taken up of a primary angioplasty. CAG showed high thrombus burden in LAD with proximal LAD total occlusion. After opening LAD, more like distal LAD with a parallel large diagonal. Thrombus aspiration done, achieved TIMI-III flow, same day patient developed chest pain with mild ST- elevation hence, CAG done showed stent thrombosis with total occlusion. PTCA to LAD done and Vessel opened. Patient started on Tirofiban infusion and changed antiplatelets to Ticagrelor. He was observed to post PCI for 5 days. No further cardiac events. Pre discharge echo showed RWMA Apical anterior wall and Antero-septal wall, but only mild LV dysfunction. He was advised DAPT with Ticagrelor and risk of stent thrombosis.

DISCHARGE MEDICATION:

1. TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. MET XL ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. AXCER 90 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ECOSPRIN 75 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. HOMOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. IVABID 5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS WITH ECG, CBC AND RP2 TO REPORTS TO CARDIAC OPD

ARH1.0001233309

Name

Mr. RAJAIAH PULI

Patient Identifier

ARHIP56631

Age

70Yr
0Mth
6Days

Sex

Male

Date of Admission

15-Jul-2022

**Date of Discharge
MLC No**

Address

Other,Other

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:123
A

Primary Consultant

DR. NIKHIL GOLI --NEUROLOGY

CVA, ACUTE INFARCT IN POSTERIOR CIRCULATION

C/o Vomiting 5-6 episodes

Weakness of right upper limb and lower limb since 1 day

AT ADMISSION:

Afebrile

PR: 84/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 70 years old male patient Mr. RAJAIAH PULI came with c/o Vomiting 5-6 episodes, weakness of right upper limb and lower limb since 1 day. All necessary investigations were done and diagnosed as CVA, ACUTE INFARCT IN POSTERIOR CIRCULATION. Managed conservatively. Patient condition

improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ZORYL-M1 TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
5. TAB. BACLOF 10 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
6. SYP. MUCAINGEL 2tsp TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
7. HINEX PROTEIN POWDER

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001233423		Name	Mr. MASU SHANKAR
Patient Identifier	ARHIP56677	Age	60Yr 0Mth 3Days
Sex	Male	Date of Admission	18-Jul-2022
Date of Discharge			
MLC No			
Address	Krishna Colony Jaya Shankar Bhupalli,Adilabad(Adilabad),Telangana	Ward/Bed No	Second Floor, Semi Private, Bed no:105 B
Primary Consultant	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	Consultants	
Surgeons	Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY	Anesthesiologists	Dr. K.S.D.KRISHNA KIRAN--ANAESTHESIOLOGY

☐ Diagnosi

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Diagnosis

[Add
Diagnosis](#)

ARHIP56677	ARH1.000123342
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☐ Surgery / Procedures
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LT LL FASCIOTOMY				

LEFT LOWER LIMB CELLULITIS

SURGERY: LEFT LOWER LIMB FASCIOTOMY DONE ON 18/07/2022

c/o left leg swelling, redness, pain since 3-4 days

Known case of hypertension

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 60 yr old male patient Mr. MASU SHANKAR came with c/o left leg swelling, redness, pain since 3-4 days. Known case of hypertension. All necessary investigations done and diagnosed as LEFT LOWER LIMB CELLULITIS, SURGERY: LEFT LOWER LIMB FASCIOTOMY DONE ON 18/07/2022. Findings: Severely oedematous left lower limb with multiple blisters noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: CLINCIN 300MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: ROTAVAUULT THRICE DAILY AT 8AM, 2PM, 8PM FOR 7 DAYS.
4. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
6. TAB: FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 15 DAYS.
7. TAB: DYTOR PLUS 5 MG ONCE DAILY AT 8AM FOR 5 DAYS.
8. SYP. SUCROFIL-O 2tsp THRICE DAILY AT 8AM, 2PM, 8PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001233414

Name		Mr. SRINIVAS THUPAKULA	
Patient Identifier	ARHIP56680	Age	49Yr 6Mth 3Days
Sex	Male	Date of Admission	18-Jul-2022
Date of Discharge			
MLC No			
Address	1-33, TANGALLAPALLI,Siddipet,Telangana	Ward/ Bed No	First Floor, HDU, Bed no:HD U 1
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,		

ECTATIC CORONARIES WITH SLOW FLOW

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 49 years old male patient Mr. SRINIVAS THUPAKULA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD-CSA, FC-III DOE, NO HF, SR, CORONARY ANGIOGRAM (20/07/2022) showed ECTATIC NORMAL CORONARIES. PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE
- 2) TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE
- 3) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 4) TAB. GLIMESTAR 500 MG ONCE DAILY AT 8AM BBF TO CONTINUE

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233313

Name

Ms. NELLAVVA
PENTAGARI

**Patient
Identifier**

ARHIP56638

Age

80Yr
0Mth
6Days

Sex

Female

**Date of
Admission**

15-Jul-
2022

**Date of
Discharge
MLC No**

Address

Other,Other

**Ward/Bed
No**

Second
Floor,
Female
General Ward,
Bed
no:GW
1

**Primary
Consultant
Surgeons**

DR. NIKHIL GOLI --NEUROLOGY

Consultants

ACUTE INFARCT IN LEFT HIGH PARIETAL LOBE

Weakness of right upper limb and lower limb, slurring of speech
Known case of hypertension not on medication

AT ADMISSION:

Afebrile

PR: 86/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 80 years old female patient MS. NELLAVVA PENTAGARI came with c/o Weakness of right upper limb and lower limb, slurring of speech, Known case of hypertension not on medication. All necessary investigations were done and diagnosed as ACUTE INFARCT IN LEFT HIGH PARIETAL LOBE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. SARTEL 20MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS IN DR. NIKHIL GOLI sir OPD.

ARH1.0001233246

Name

Mr.
BHARADWAJ
PATHURI

Patient Identifier ARHIP56614

Age 35Yr
0Mth
7Days

Sex Male

Date of Admission 14-Jul-2022

Date of Discharge
MLC No

Address H.NO:4-
144,NARAYANARAOPALLI,SULTHANABAD,PEDDAPALLY,Other,Ot
her

Ward/ Bed No Second
Floor,
Male
General Ward,
Bed
no:GW
15

Primary Consultant DR. SUBRAT KUMAR SOREN

TRAUMATIC BRAIN INJURY
SAH
RIGHT TENTORIAL SDH
FRACTURE RIGHT DISTAL END RADIUS

Alleged history of RTA, sustained head injury and Maxillofacial injury on 13/07/2022

AT ADMISSION:

Afebrile

PR: 82/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

GCS-E3,V5,M6

A 35 years old male patient Mr. BHARADWAJ PATHURI came with alleged history of RTA, sustained head injury and maxillofacial injury on 13/07/2022. All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY, SAH, RIGHT TENTORIAL SDH, FRACTURE RIGHT DISTAL END RADIUS. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. AUGMENTIN DUO 625 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
- 2) TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 3) TAB. THIAMINE 100 MG ONCE DAILY AT 2PM FOR 10 DAYS
- 4) TAB. DOLO 650 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) TAB. PANTOP 40 MG ONCE DAILY AT 7AM BBF FOR 10 DAYS

REVIEW AFTER 11 DAYS IN NEUROSURGERY OPD

ARH1.0001233412

Name

Mrs.
VENKATAMMA
ORSU

Patient Identifier

ARHIP56675

Age

67Yr
6Mth
3Days

Sex

Female

**Date of
Admission**

18-Jul-
2022

**Date of Discharge
MLC No**

Address

1-123/A, MARPADAGA,JANGAON-
7893632366,Nalgonda,Telangana

**Ward/Bed
No**

Second
Floor,
Female
Genera
l Ward,
Bed
no:GW
3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR

NORMAL LV FUNCTION [EF-60%]

CORONARY ANGIOGRAM (20/07/2022) - NORMAL EPICARDIAL CORONARIES
PLAN MEDICAL MANAGEMENT

R/F : T2DM

C/o chest pain since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 67 years old female patient Mrs. VENKATAMMA ORSU came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (20/07/2022) - NORMAL EPICARDIAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. INJ HUMAN MIXTURED 30/70 30 Units AT 8AM 20 Units AT 8PM CONTINUE
5. TAB. PANTOCID DSR ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

56701

ARH1.0001025744

Name

Mr. NARSAIAH
JAGASANDRAPU

Patient Identifier

ARHIP56701

Age

65Yr 0Mth
5Days

Sex

Male

**Date of
Admission**

19-Jul-
2022

**Date of Discharge
MLC No**

Address

RAIKAL,Karimnagar,Andhra Pradesh

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU1
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

S

K/C/O CAD IWSTEMI (16/09/2021)

MILD LVF (16/09/2021)

SEVERE ANAEMIA, CAD SEVERE MR, MODERATE PAH, SEVERE LV DISFUNTION (13/02/2022)

P/P: ADHF (RECURRENT ADMISSION)

ICMP (SEVERE MR)

C/o SOB on exertion since 1 day.

S/P POST PTCA TO RCA (27/7/2012).

ON ADMISSION

Pt c/c

Afebrile

PR-86/min

BP-110/70mmhg

RR-20/min

RS-BAE+,
CVS-S1S2+
P/A-Soft, BS+
SPO2-99%

A 65 years old male patient Mr. NARSAIAH JAGASANDRAPU, presented to hospital with c/o SOB on exertion since 1 day. All necessary investigations were done and diagnosed as K/C/O CAD IWSTEMI (16/09/2021), MILD LVF (16/09/2021), SEVERE ANAEMIA, CAD SEVERE MR, MODERATE PAH, SEVERE LV DISFUNTION (13/02/2022), P/P: ADHF (RECURRENT ADMISSION), ICMP (SEVERE MR). Patient was treated conservatively. CTVS consultation taken in view of severe MR (MVR+TV repair) is advised. Now patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION

1. TAB. CARDIVAS 6.25MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
2. TAB. RAMISTAR 5 MG ONCE DAILY AT 8AM TO CONTINUE
3. TAB. DYTOR PLUS 20MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. TONACT 20MG ONCE DAILY AT 8PM TO CONTINUE.
7. CAP. AUTRIN ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 1 WEEK IN CARDIAC OPD

RAYAMALLU %%%%%%%%%56417

SEPSIS WITH MODS AND ACUTE CVA

C/o generalised weakness, decreased urine output

AT ADMISSION:

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. RAYAMALLU came with above mentioned complaints. Patient was taken over from Urology on 05/07/ 2022 after patient had undergone TURP and optical urethrotomy. Patient was drowsy was in hypotension and was diagnosed to have sepsis with multiorgan dysfunction syndrome. Patient was started on INJ. MEROPENEM according to creatinine clearance blood cultures and urine cultures were sent. Patient was intubated in view of poor GCS. Blood culture was sterile urine culture showed growth and antibiotics were adjusted according to sensitivity. Patient continued to require mechanical ventilation. Patient recovered from hypotension and acute kidney injury. Despite broad spectrum antibiotics patient continued to have fever spikes . Patient was extubated on 13/07 /22. Was maintaining saturation of 3 L/min of oxygen. On 14/07/22 in the night patient's GCS drop to 3 / 15 and he had paucity of limb movements an MRI brain revealed posterior circulation infarcts. A Neurologist consultation was taken and advice was followed patient was re intubated in view of poor GCS. Patients urine output decreased nephrology consultation was taken and 2 cycles of/ were done. Patient's condition did not improve with the above treatment interventions. On 20/07/2022 patient had sudden cardiac arrest at so and so time CPR was initiated according to ACLS protocol despite best efforts patient could not be revived and declared dead at so and so time.

ARH1.0001233083

Name

Mr.
YELLAVVA
NERELLA

Patient
Identifier

ARHIP56531

Age

70Yr
0Mth
1Days

Sex

Male

Date of
Admission

08-Jul-
2022

Expired Date 09-Jul-2022

MLC No

Address

7-1-63
MANKAMMARHOTA,Karimnagar,Telang
ana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
7

Primary
Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

Consultants

Surgeons

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

Anesthesiologi
sts

Diagnosis
S

Diagnosis

Disease	Disease Type
.	

CAD ACUTE ANTERIOR WALL ST ELEVATED MYOCARDIAL INFRACTION,SEVERE LV DYSFUNCTION
EF;15%,HYPERTENSION,TYPE2DM
PRIMARY PTCA TO LAD DONE ON 8/07/2022

C/o SOB on exertion, chest pain since 5 days

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 70years old female patient Mr. YELLAVVA NERELLA came with c/o SOB on exertion, chest pain since 5 days. All necessary investigations were done and diagnosed as CAD

ACUTE ANTERIOR WALL ST ELEVATED MYOCARDIAL INFRACTION,SEVERE LV DYSFUNCTION
EF;15%,HYPERTENSION,TYPE2DM

PRIMARY PTCA TO LAD DONE ON 8/07/2022. Poor prognosis explained to the patient attendants.
On 09.07.2022 at 11.15 AM patient got cardiac arrest. INJ. Atropine and INJ. ADRENALINE
given and patient desaturated, immediately, emergency intubation was done and connected
to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given.
CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was
continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt,
declared death at 12.25 PM on 09/07/2022.

CAUSE OF DEATH

CAD ACUTE ANTERIOR WALL ST ELEVATED MYOCARDIAL INFRACTION,SEVERE LV DYSFUNCTION
EF;15%,HYPERTENSION,TYPE2DM
PRIMARY PTCA TO LAD DONE ON 8/07/2022

ARH1.0001233312

Name

Ms. MALLAVA
KOTTE

Patient Identifier

ARHIP56634

Age

57Yr
0Mth
1Days

Sex

Female

**Date of
Admission**

15-Jul-
2022

Expired Date

16-Jul-2022

MLC No

Address

Other,Other

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
4

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

**Consultants
Anesthesiologi
sts**

Diagnosis
S

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFARCTION.	

C/o chest pain since 1 day

AT ADMISSION:

PR: 80/min

BP: 160/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 57 years old female patient Ms. MALLAVA KOTTE came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFARCTION. Poor prognosis explained to the patient attendants. On 16.07.2022 at 2.45 PM patient was unresponsiveness. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and inotropic support was given. DC shock 200 J given, patient not responded. CPR started immediately according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 04.36 PM on 16/07/2022.

CAUSE OF DEATH

SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO CORONARY ARTERY DISEASE ANTERIOR WALL MYOCARDIAL INFARCTION.

ARH1.0001233453

Name

Mrs. JYOTHI
SHANIGARAM

Patient Identifier

ARHIP56694

Age

29 Yr
1Mth
3Days

Sex

Female

**Date of
Admission**

19-Jul-
2022

**Date of Discharge
MLC No**

Address

15-17/1,
CHELPUR,Karimnagar,Telangana

**Ward/Bed
No**

First
Floor,
MICU,
Bed
no:MIC
U 8

Primary Consultant

Dr. KRISHNA CHAITANYA M

UNSTABLE ANGINA
NORMAL LV FUNCTION
NO HF
CORONARY ANGIOGRAM - NORMAL CORONARIES

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 90/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 29 years old female patient Mrs. JYOTHI SHANIGARAM came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as UNSTABLE ANGINA, NORMAL LV FUNCTION, NO HF, CORONARY ANGIOGRAM done on 21/07/2022 - NORMAL CORONARIES. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1.TAB. ROSUVAS 5 MG ONCE IN A DAY AT 8 P.M. FOR 3 MONTHS

REVIEW AFTER 3 MONTHS / SOS IN CARDIAC OPD

ARH1.0001214687

Name	Mrs. VASAM ANJAVVA		
Patient Identifier	ARHIP56687	Age	71Yr 1Mth 2Days
Sex	Female	Date of Admission	18-Jul-2022
Date of Discharge			
MLC No			
Address	SUBRAMANYAMNAGAR,Sircilla,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

UNSTABLE ANGINA WITH ECG CHANGES
KNOWN CASE OF COMPLETE HEART BLOCK
S/P PPI [2009]
CORONARY ANGIOGRAM + PPI DONE ON 20/06/21 - MILD CAD
NORMAL LV FUNCTION
PPI DONE ON 22/06/22 WITH MEDTRONIC (VVIR)
CORONARY ANGIOGRAM DONE ON 21/07/22 - MILD DISEASE
PLAN MEDICAL MANAGEMENT
R/F: HTN

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 71 years old female patient Mrs. VASAM ANJAVVA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as UNSTABLE ANGINA WITH ECG CHANGES, KNOWN CASE OF COMPLETE HEART BLOCK, S/P PPI [2009], CORONARY ANGIOGRAM + PPI DONE ON 20/06/21 - MILD CAD NORMAL LV FUNCTION, PPI DONE ON 22/06/22 WITH MEDTRONIC (VVIR), CORONARY ANGIOGRAM DONE ON 21/07/22 - MILD DISEASE, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB: DILINIP 5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PAN 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233428		Name	Ms. BHADURAMM A B
Patient Identifier	ARHIP56684	Age	60Yr 0Mth 4Days
Sex	Female	Date of Admission	18-Jul-2022
Date of Discharge			
MLC No			
Address	Other,Other	Ward/Bed No	First Floor, HDU, Bed no:HD U 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, NSTEMI

MODERATE LV DYSFUNCTION, EF-40%

CORONARY ANGIOGRAM DONE ON 19/07/2022 - CAD-SVD (LAD),

PTCA+DES TO LAD WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 19/07/2022
R/F: HTN

C/o sudden onset chest pain a/w sweating

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 60 years old female patient Mrs. BHADURAMMA came with c/o sudden onset chest pain a/w sweating. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, NSTEMI, MODERATE LV DYSFUNCTION, EF-40%, CORONARY ANGIOGRAM DONE ON 19/07/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 23 MM XIENCE XPEDITION DONE ON 19/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AX CER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233160	Name		Mr. CHEKKAPALLI SARWIAH	
Patient Identifier		ARHIP56629	Age	63Yr 0Mth 11Days
Sex		Male	Date of Admission	15-Jul-2022
Date of Discharge				
MLC No				
Address		bommena,jagityal,Karimnagar,Telangan	Ward/Bed No	First Floor, CT POST, Bed no:CT 5
Primary Consultant		Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	Consultants	
Surgeons		Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	Anesthesiologists	Dr. K.S.D.KRISHNA KIRAN-- ANAESTHESIOLOGY

☐ Diagnosi

S

Diagnosis

[Add
Diagnosis](#)

ARHIP56629	ARH1.000123316
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☐ Surgery / Procedures
Done

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
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RIGHT LOWER LIMB PAD [PERIPHERAL ARTERIAL DISEASE] ATHEROSCLEROTIC ORIGIN,
DM+HTN+RENAL DYSFUNCTION
SURGERY : RIGHT FEMORO POPLITEAL ARTERIAL BYPASS GRAFFTING WITH 6 MM DACRON GRAFT+
EXCISION OF RIGHT 2nd TOE DONE ON 18/07/2022

C/o pain in b/l lower limbs

H/o gangrene/blackish discolouration

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 63 years old male patient Mr. CHEKKAPALLI SARWIAH presented to hospital with c/o pain in b/l lower limbs, h/o gangrene/blackish discolouration. All necessary investigations were done and diagnosed as RIGHT LOWER LIMB PAD [PERIPHERAL ARTERIAL DISEASE] ATHEROSCLEROTIC ORIGIN, DM+HTN+RENAL DYSFUNCTION, SURGERY : RIGHT FEMORO POPLITEAL ARTERIAL BYPASS GRAFTING WITH 6 MM DACRON GRAFT+ EXCISION OF RIGHT 2nd TOE DONE ON 18/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

BMI is 17.3 kg/m².

Sr. Creatinine report on 19.07.2022 1.1 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. ACITROM 2 MG ONCE DAILY AT 7PM TO CONTINUE.
- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. GLYCOMET GP1 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. ND-VIT ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG ONCE DAILY AT 8AM FOR 5 DAYS.
- 7) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.
- 9) TAB. CALPOL 500 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001138156

Name

Mr. SRINIVAS
GADDE

Patient Identifier

ARHIP56542

Age

50Yr
10Mth
25Days

Sex

Male

**Date of
Admission**

08-Jul-
2022

**Date of Discharge
MLC No**

11-Jul-2022

Address

3-42/1
REKURTHI, Karimnagar, Telangana


Ward/Bed No

First
Floor,
CICU ,
Bed
no: CICU1
1

**Primary Consultant
Surgeons**

Dr. Vidya Sagar A--CARDIOLOGY
Dr. Vidya Sagar A--CARDIOLOGY

**Consultants
Anesthesiologists**

 **Diagnosis**
S

Diagnosis

Disease	Disease Type
---------	--------------

CAD NSTEMI
CAG DONE ON 11/7/2022
R/F;DM2,HTN

C/o chest pain, radiating to back since 3 days

AT ADMISSION:

Pt conscious, coherent

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. SRINIVAS GADDE came with c/o chest pain, radiating to back since 3 days. All necessary investigations were done and diagnosed as CAD NSTEMI, CAG DONE ON 11/07/2022 showed CAD-SVD(RCA) , plan PTCA to RCA. Patient attendants requested for discharge, hence patient is getting discharged at request.

ARH1.0001233219		Name	Mr. LAXMINARAYANA DUDAM
Patient Identifier	ARHIP56597	Age	66Yr 0Mth 9Days
Sex	Male	Date of Admission	13-Jul-2022
Date of Discharge	14-Jul-2022		
MLC No			
Address	1-4-31 VENKAMPET, Karimnagar, Telangana	Ward/Bed No	First Floor, CICU , Bed no: CICU 7
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	Consultants	
Surgeons	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY	Anesthesiologists	

Diagnosis
S

Diagnosis

Disease	Disease Type
CORONARY ARTERY DISEASE ANTERIOR WALL WALL MYOCARDIAL INFRACTION AND SEVER CORDIOGENIC SHOCK, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%, PRIMARY:CAG+PTCA DES TO LAD 1STENT DONE ON 13/07/2022.	

Complaint of chest pain and shortness of breath since 3 days

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 66 years old male patient Mr. LAXMINARAYANA DUDAM came with c/o chest pain and shortness of breath since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE ANTERIOR WALL WALL MYOCARDIAL INFRACTION AND SEVER CORDIOGENIC SHOCK, SEVERE LV SYSTOLIC DYSFUNCTION EF:30%, Coronary angiogram done on 13/07/2022 showed LAD type III arterial thrombotic occlusion LCX mild disease RCA mild disease Primary PTCA to LAD thrombotic occlusion PTCA to LAD with 2.5 x 48 mm done Patient attendants requested for discharge hence patient discharged under LAMA

ARH1.0001233253

Name

Mr. B MAHESH

Patient Identifier

ARHIP56613

Age

28Yr
0Mth
9Days

Sex

Male

Date of Admission

14-Jul-2022

Date of Discharge

15-Jul-2022

MLC No

Address

.,Asifabad,Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
9

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

Consultants

Surgeons

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
PANCREATITIS PANCREATIC PSUEDOCYST PERSISTANT HYPOKALEMIA PROLONGED QT INTERVAL SECONDARY TO DYSELECTROLYTEMIA.	

Complaint of chest pain on and off since 5 months

AT ADMISSION:

Afebrile

PR: 78/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft,

A 28 years old male patient Mr. MAHESH came with complaint of chest pain on and off since 5 months. All necessary investigations were done and diagnosed as Sinus Bradycardia, Prolonged QT interval secondary to dyselectrolytes, persistent hypokalaemia. Known case of pancreatitis and pancreatic pseudocyst for which treatment was taken in Outside Hospital . In view of dyselectrolytaemia intravenous correction of potassium, Magnesium and calcium advised. Risk of VT/VF and sudden cardiac arrest explained to patient attenders. Patient and patient attenders are not willing for further treatment hence patient is being discharged at request.

ARH1.0001233487

Name

Mr. T
SHANKAR

Patient Identifier

ARHIP56707

Age 53Yr 0Mth
4Days

Sex

Male

Date of Admission 20-Jul-2022

**Date of Discharge
MLC No**

Address

CHENNUR
MANCHERIYAL,Adilabad(Adilabad),Telangana

**Ward/
Bed No** First
Floor,
CICU ,
Bed
no:CICU1
1

Primary Consultant

Dr. KRISHNA CHAITANYA

S

CORONARY ARTERY DISEASE, IWMI

CORONARY ANGIOGRAM DONE ON 20/07/2022 – CAD-SVD (LCX)

PRIMARY PTCA+ TO LCX WITH 2.75 X 28 MM 3V ASTRA DONE ON 20/07/2022

GOOD LV FUNCTION, NO HF, SR

C/o chest pain radiating to back since 2 days

AT ADMISSION:

Afebrile

PR: 75/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 53 years old male patient Mr. SHANKAR presented with complaint of chest pain. On evaluation, diagnosed to have IW-STEMI. CAG done showed LCX thrombotic total occlusion. Primary PTCA to LCX with 2.75 X 28 mm 3V Astra done, TIMI-III flow. Good result. Patient is asymptomatic and stable at discharge

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 5) TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) SYP. POTKLOR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 3 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH CBC, RP2 REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233435

Name

Mr. POCHAM
DEVA

**Patient
Identifier**

ARHIP56691

Age

46Yr
7Mth
4Days

Sex

Male

**Date of
Admission**

19-Jul-
2022

**Date of
Discharge
MLC No**

Address

1-110,
PALAKURTHI, PEDDAPALLI, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 9

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

DCMP, LBBB, SR, MODERATE LV DYSFUNCTION (EF - 40%)
CORONARY ANGIOGRAM (22/07/2022) -NORMAL CORONARIES

PLAN MEDICAL MANAGEMENT

C/o chest discomfort since few days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old male patient Mr. POCHAM DEVA came with c/o chest discomfort since few days. All necessary investigations were done and diagnosed as DCMP, LBBB, SR, MODERATE LV DYSFUNCTION (EF - 40%), CORONARY ANGIOGRAM (22/07/2022) -NORMAL CORONARIES, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. COVERSYL 2 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233493

Name

Mr. MADEPALLI
MALLESH

Patient Identifier ARHIP56711

Age 40Yr
6Mth
22Days

Sex Male

Date of Admission 20-Jul-2022

Date of Discharge
MLC No

Address 170,Ranapur,PEDDAPALLI,Karimnagar,Telangan

Ward/Bed No First Floor,
HDU,
Bed no:HD
U 2

Primary Consultant Dr. KRISHNA CHAITANYA

CORONARY ARTERY DISEASE, AWSTEMI

MODERATE LV DYSFUNCTION

CONTROL HF, SR, TOBACCO+

CORONARY ANGIOGRAM DONE ON 20/07/2022 - CAD-TVD (LAD,LCX,RCA)

PRIMARY PTCA+DES TO LAD [2 STENTS] PROXIMAL LAD WITH 3.0 X 32 MM METAFOR, MID LAD WITH 2.5 X 20 MM 3V ASTRA, DONE ON 20/07/2022

C/o chest pain radiating to back since, SOB since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 40 years old male patient Mr. MADEPALLI MALLESH presented with complaint of chest pain. On evaluation, diagnosed to have AAMI. Primary PTCA done to LAD successfully (proximal LAD 3.0 X 32 MM METAFOR, mid LAD 2.5 X 20 MM 3V ASTRA). Need to stop smoking and risk of stent thrombosis explained to family. He was asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. IVABID 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
- 8) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 9) TAB. RENOSAVE TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 10) TAB. SOBINEX TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 11) TAB. KETO CHECK TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2, ECG REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS / HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR / ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233302

Name

Mr. SINGU
RAMESH

Patient Identifier

ARHIP56705

Age

49Yr
0Mth
8Days

Sex

Male

**Date of
Admission**

19-Jul-
2022

**Date of Discharge
MLC No**

Address

METPALLI
JAGITIAL ,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU, Bed
no:HDU1
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , UNSTABLE ANGINA
NORMAL LV SYSTOLIC FUNCTION, EF-60%
CORONARY ANGIOGRAM DONE ON 22/07/2022 - CAD-DVD [LAD, LCX]

PLAN CABG WITH GRAFTS TO LAD, DISTAL LCX AND OM

C/o chest pain since few days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 49 years old male patient Mr. RAMESH came with c/o chest pain since few days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , UNSTABLE ANGINA, CORONARY ANGIOGRAM DONE ON 22/07/2022 – CAD-DVD [LAD, LCX], PLAN CABG WITH GRAFTS TO LAD, DISTAL LCX AND OM. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 7AM FOR 10 DAYS.

REVIEW AFTER 10 DAYS IN CARDIAC OPD

56727 SATHAIAH 65

CORONARY ARTERY DISEASE, IWM

NORMAL LV FUNCTION
FC-II, III AOE, NO HF, SR

HYPERTENSION, SMOKER

C/o chest pain radiating to back since, SOB since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. SATHAIAH presented with complaint of chest pain. On evaluation, diagnosed to have IWSTEMI. CAG done showed double vessel disease. PTCA to OM & LAD successfully (OM1 WITH 2.25 X 18 MM BIOFREEDOM, LAD WITH 3.0 X 12 MM XIENCE XPEDITION). Good result. TIMI III Flow. Patient was counselled about need to stop smoking and risk of stent thrombosis. He is asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

-
- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
 - 2) TAB. NIKORAN 5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
 - 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
 - 4) TAB. MET-XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
 - 5) TAB. MONTEK-LC TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
 - 6) SYP. ASCORIL LS THRICE DAILY AT 8AM 2PM AND 8PM
 - 7) TAB. PAN 40MG ONCE DAILY AT 8AM FOR 1 WEEK.
 - 8) TAB. AXCER 90 MG TWICE DAILY AT 8AM AND 8PM FOR 1 WEEK.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP2, ECG REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001220636

Name	Mrs. VASANTHA SANGAM		
Patient Identifier	ARHIP56623	Age	75Yr 10Mth 23Days
Sex	Female	Date of Admission	15-Jul-2022
Date of Discharge			
MLC No			
Address	H.NO:5-15,THOTAPALLY,BEJJENKI,SIDDIPET,Other,Telangana		Ward/Bed No
Primary Consultant	Dr SOMASHEKAR K(MS,MCH		First Floor, CT POST, Bed no:CT 1

CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P PTCA & STENTING TO LAD + LCX+ISR OF LAD STENT+AWMI+DM+HTN

SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA] DONE ON 19/07/2022.

C/o chest pain radiating to back since 2 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 75 years old female patient Mrs. VASANTHA SANGAM presented to hospital with c/o chest pain radiating to back since 6 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P PTCA & STENTING TO LAD + LCX+ISR OF LAD STENT+AWMI+DM+HTN, SURGERY - CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO PDA] DONE ON 19/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED PARADOXICAL SEPTAL MOTION, MILD LV DYSFUNCTION, MILD AR, TR, PAH, EF-45%, NO PE/CLOT/VEG.

BMI is ___ kg/m².

Sr. Creatinine report on 20.07.2022 0.9 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. THYRONORM 75 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
- 5) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. CALPOL 500 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 9) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9AM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH FBS, PLBS REPORTS

ARH1.0001157553

Name

Mrs.
MAHAMAD
FATEEMA

Patient Identifier

ARHIP56697

Age

69Yr
0Mth
28Days

Sex

Female

**Date of
Admission**

19-Jul-
2022

**Date of Discharge
MLC No**

Address

1-75, REPAKA, ELLANTHAKUNTA,
KARIMNAGAR, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no: HD
U 4

Primary Consultant

Dr. KRISHNA CHAITANYA M

CORONARY ARTERY DISEASE , NSTEMI

NORMAL LV FUNCTION, EF-60%

S/P PCI (2013)

CORONARY ANGIOGRAM DONE ON 22/07/2022 - CAD-TVD

PLAN CABG.

C/o chest pain radiating to the back and left arm

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 69 years old female patient Mrs. MAHAMAD FATEEMA came with c/o chest pain radiating to the back and left arm. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, NORMAL LV FUNCTION, EF-60%, S/P PCI (2013), CORONARY ANGIOGRAM DONE ON 22/07/2022 – CAD-TVD , PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 5) TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001233477

	Name	Mr. JALALUDDIN MOHAMMED		
Patient Identifier	ARHIP56692	Age	65Yr 0Mth 4Days	
Sex	Male	Date of Admission	19-Jul-2022	
Date of Discharge				
MLC No				
Address	5-2-102,OSMANPURA STREET,JAGTIAL,Karimnagar,Telangana		Ward/ Bed No	First Floor, CICU , Bed no:CICU 7
Primary Consultant	Dr. KRISHNA CHAITANYA M			

CORONARY ARTERY DISEASE, NSTEMI, SR

NORMAL LV SYSTOLIC FUNCTION, EF-55%
POST PTCA TO RCA STENT IN 2002, S/P CABG IN 2011
CORONARY ANGIOGRAM DONE ON 23/07/2022

LIMA-LAD PATENT

RSVG-OM OCCLUDED

OSTIAL LM-90% STENOSIS

PLAN: PTCA+DES TO LMCA

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 65 years old male patient Mr. JALALUDDIN MOHAMMED presented with complaint of chest pain since 1 day. On evaluation, diagnosed to have CORONARY ARTERY DISEASE, NSTEMI, SR, NORMAL LV SYSTOLIC FUNCTION, EF-55%, POST PTCA TO RCA STENT IN 2002, S/P CABG IN 2011, CORONARY ANGIOGRAM DONE ON 23/07/2022 LIMA-LAD PATENT, RSVG-OM OCCLUDED, OSTIAL LM-90% STENOSIS , PLAN: PTCA+DES TO LMCA . He was asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. MET-XL 25MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 6) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001233437

Name		Mr. RAKTHANI MALLESHAM	
Patient Identifier	ARHIP56712	Age	70Yr 0Mth 4Days
Sex	Male	Date of Admission	20-Jul-2022
Date of Discharge			
MLC No			
Address	himmath nagar,gangadhara,Karimnagar,Telanga na	Ward/ Bed No	First Floor, MICU, Bed no:MIC U 11
Primary Consultant	Dr. KRISHNA CHAITANYA M		

CORONARY ARTERY DISEASE , IWM I

CAG+AORTIC ROOT ANGIO DONE ON 23/07/2022 – MINOR CAD, DILATED AORTIC ROOF

SEVERE AORTIC REGURGITATION

PLAN AVR.

C/o shortiness of breath, sweating since 1 day

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 70 years old male patient Mr. RAKTHANI MALLESHAM came with c/o shortness of breath, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , IWMI, CAG+AORTIC ROOT ANGIO DONE ON 23/07/2022 - MINOR CAD, DILATED AORTIC ROOF, SEVERE AORTIC REGURGITATION. CTVS consultation taken and advice AVR. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. PANTOCID 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 6) TAB. MET-XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RAMIPRIL 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001098966

Patient Identifier

ARHIP56666

Sex

Male

Date of Discharge

18-Jul-2022

MLC No

Address

SUGLAMPALLY,Karimnagar,Telangana

Name

Mr. VENGALA
SRINIVAS

Age

52Yr
5Mth
20Days

**Date of
Admission**

17-Jul-
2022

Ward/Bed No

First
Floor,

MICU,
Bed
no:MIC
U 8

Primary Consultant

Dr. RAMCHANDER
TORREM(DM(NEPHROLOGY)
(NIMS),RENAL TRANSPLANT PHYSICIAN)--
NEPHROLOGY

Consultants

Surgeons

Anesthesiologists

☐ **Diagnosis**
S

Diagnosis

Disease	Disease Type
K/C/O CKD ON MHD.	Pd

C/o shortness of breath since 1 day

Known case of diabetic mellitus, hypertension and CKD on MHD

AT ADMISSION:

Afebrile

PR: 90/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 52 years old male patient Mr. VENGALA SRINIVAS came with c/o shortness of breath since 1 day. All necessary investigations were done and diagnosed as K/C/O CKD ON MHD. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CILACAR M 10/10 **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
2. TAB. NICARDIA RETARD ONCE DAILY AT 8AM TO CONTINUE
3. TAB. DYTOR 10 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
4. TAB. METOL ONCE DAILY AT 8AM FOR 5 DAYS
5. TAB. FAROALFA ONCE DAILY AT 8AM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233586

Name

Mrs. CH
PUSHPAMMA

Patient
Identifier

ARHIP56736

Age

71Yr
0Mth
0Days

Sex

Female

Date of
Admission

22-Jul-
2022

Expired Date 22-Jul-2022

MLC No

Address

ARNAKONDA CHOPADANDI
KARIMNAGAR, Karimnagar, Telangana

Ward/
Bed No

First
Floor,
CICU ,
Bed
no: CICU
7

Primary
Consultant

Dr. KRISHNA CHAITANYA M (



Diagnosis

Diagnosis

Disease	Disease Type
PONTINE INFARCT	

C/o Retrosternal chest pain since 7 days

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 71 years old female patient Mrs. CH PUSHAMMA came with c/o retrosternal chest pain since 7 days. Patient presented with dyspnoea FC-IV, chest pain. On evaluation patient in cardiogenic shock, pulmonary oedema, severe MR, severe PAH. Guarded prognosis and poor chance of survival explained to family members. They were willing for high risk angiogram followed by angioplasty. They were willing hence it taken up as high risk primary PTCA. Patient in cardiogenic shock on inotropic support. PTCA to LAD and RCA done. Postop day one patient suddenly had VT/VF and cardiac arrest. CPR and ACLS protocol initiated and endotracheal intubation done and connected to mechanical ventilator. She did not have any improvement in blood pressure. Patient had refractory cardiogenic shock, hence could not be resuscitated. Informed to patient attendants patient declared dead on 22/07/2022 at 3.11 P.M.

ARH1.0001233570

Name

Mr.
MOHAMMAD
GOUSE KHAN

Patient Identifier

ARHIP56729

Age

59Yr
0Mth
4Days

Sex

Male

Date of Admission

21-Jul-2022

Date of Discharge
MLC No

24-Jul-2022

Address

10-4-508, SUBHASH
NAGAR,Karimnagar,Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
8

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Anesthesiologists

Diagnosis



S

Diagnosis

Disease

Disease Type

ATYPICAL CHEST PAIN,SR,NORMAL LV DYSFUNCTION EF;60%
SON DECEASED 7DAYS BACK
CAG(23/07/2022);NORMAL CORONARIES
PLAN;MEDICAL MANAGEMENT

C/o Retrosternal chest pain, radiating to back since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 59 years old male patient Mr. MOHAMMAD GOUSE KHAN came with c/o retrosternal chest pain, radiating to back since 1 day. On evaluation diagnosed as ATYPICAL CHEST PAIN,SR,NORMAL LV DYSFUNCTION EF;60%, SON DECEASED 7DAYS BACK, CAG(23/07/2022);NORMAL CORONARIES, PLAN;MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. RESTYL 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB: RABIFAST 20MG ONCE DAILY AT 8AM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

PatientDetails

UHID	ARH1.0001233483	Name	Mrs. LAXMI MUDDAM
Patient Identifier	ARHIP56703	Age	55Yr 6Mth 6Days
Sex	Female	Date of Admission	19-Jul-2022
Date of Discharge			
MLC No			
Address	2-7/2, THIPPANNAPETA,JAGTIAL,Karimnagar,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU3
Primary Consultant	Dr. KRISHNA CHAITANYA M		

COMPLETE HEART BLOCK

History of giddiness since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 100/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 55 years old female patient Mrs. LAXMI MUDDAM presented with a history of giddiness. On evaluation ECG showed complete heart block. She was admitted and TPI done. Single chamber VVIR pacemaker implanted subsequently. Good wound healing noted, asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. CILACAR 5 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. MONTEK LC ONCE DAILY AT 8PM FOR 7 DAYS
3. TAB. ACEBROPHYLLINE + N-ACETYLCYSTEINE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
4. SYP. POTKLOR 15 ml **THRICE IN A DAY AT 8 AM 2PM 8 PM** FOR 7 DAYS
5. TAB. TAXIM-O 200 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
6. TAB. PCM 500 MG FOR PAIN SOS

REVIEW AFTER 11 DAYS WITH ECG

ARH1.0001191172

Name

Mrs. B
SANTHOSHAM

**Patient
Identifier**

ARHIP56761

Age

61Yr
0Mth
18Days

Sex

Female

**Date of
Admission**

23-Jul-
2022

**Date of
Discharge
MLC No**

Address

h-no:10-4-459/1, sanjeevaiah colony,
subhashnagar,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 2

**Primary
Consultant**

Dr Chandra Shekar Sathineni(MD
(Internal Medicine))--INTERNAL
MEDICINE

METABOLIC ENCEPHALOPATHY

C/o Irrelevant talk, generalised weakness and Joint pains

Known case of hypertension, diabetes mellitus, old CVA

AT ADMISSION:

Afebrile

PR: 132/min

BP: 130/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95% on room air

P/A: Soft, BS+

A 61 years old female patient Mrs. B SANTHOSHAM came with c/o Irrelevant talk, generalised weakness and Joint pains . All necessary investigations were done and diagnosed as METABOLIC

ENCEPHALOPATHY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
- 1) TAB. ARVAST CV ONCE DAILY AT 8PM FOR 10 DAYS
 - 2) TAB. TAZOLAC CT ONCE DAILY AT 8AM FOR 10 DAYS
 - 3) TAB. STROCIT PLUS **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS
 - 4) TAB. DAPAGY ONCE DAILY AT 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

APJ1.0011369016

Name

Mrs. G.KALA
RANI GANKIDI

Patient
Identifier

ARHIP56755

Age

58Yr
1Mth
21Days

Sex

Female

Date of
Admission

23-Jul-
2022

Date of
Discharge
MLC No

25-Jul-2022

Address

KARIMNAGER,Other,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MIC
U 12

Primary
Consultant
Surgeons

DR. SRI KARAN UDDESH --INTERNAL
MEDICINE

Consultants
Anesthesiologi
sts

Diagnosi
S

Diagnosis

Disease	Disease Type
SEPTIC SHOCK KNOWN CASE OF IMMUNE THROMBOCYTOPENIC PURPURA.	

ITP

C/o fever associated with chills and vomiting 2 episodes

Known case of ITP

AT ADMISSION:

Afebrile

PR: 119/min

BP: 100/60 mmHg with NORAD infusion 8 ml/hr

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99% on room air

P/A: Soft

A 58 years old female patient Mrs. G.KALA RANI GANKIDI patient presented with above-mentioned complaints. Patient is diagnosed with septic shock, started on broad spectrum antibiotics (MEROPENEM.) haemogram revealed pancytopenia, severe neutropenia and severe anaemia. Patient was transfused with 2 units PRBC given INJ. FILGRASTRIM and 1 RDP and 1 SDP, following that Hb improved to 8.7 mg/dL. Now the patient is on ionotropic support and need for further hospitalisation explained attenders, but they are unwilling for it, so the patient is being discharged against medical advice.

ARH1.0001233572

Name	Ms. SHYAMALA NUNUSAVATH		
Patient Identifier	ARHIP56728	Age	65Yr 0Mth 4Days
Sex	Female	Date of Admission	21-Jul-2022
Date of Discharge			
MLC No			
Address	Other,Other	Ward/ Bed No	First Floor, CICU , Bed no:CICU12
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD,DM, (FNB) INTERVENTIONAL CARDIOLOGIST)--CARDIOLOGY		

CAD -IPW-STEMI
MODERATE LV DYSFUNCTION [EF-40%], SR
PRIMARY PTCA TO RCA DONE ON 21/07/22
PTCA TO LAD DONE ON 23/07/22

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 90/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft,

A 65 years old female patient Ms. SHYAMALA NUNUSAVATH presented with c/o chest pain since 1 day. On evaluation diagnosed as CAD -IPW-STEMI, MODERATE LV DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM DONE SHOWED A DVD (LAD, RCA) PRIMARY PTCA TO RCA DONE ON 21/07/22, INTERVAL PTCA TO LAD DONE ON 23/07/22, good result. Patient asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 5) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. FRUSELAC DS ½ TAB **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 8) TAB. IVABID 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS WITH CBC, RP-2, ECG

56732

ARH1.0001233584		Name	Mr. MOHAMMA D ABDUL JALIL
Patient Identifier	ARHIP56732	Age	52Yr 0Mth 4Days
Sex	Male	Date of Admission	21-Jul-2022
Date of Discharge			
MLC No			
Address	Other,Other	Ward/Bed No	First Floor, CICU , Bed no:CICU 5
Primary Consultant	Dr. KRISHNA CHAITANYA		

CAD -AWSTEMI WITH SEVERE LV DYSFUNCTION
CAG DONE SHOWED DVD
PRIMARY PTCA TO LAD DONE ON 21/07/22 AND INTERVAL PTCA TO LCX DONE ON 23/07/22
CONTROLLED HF, SR

C/o chest pain associated with profuse sweating since 1 day

AT ADMISSION:

Afebrile

PR: 92/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft,

A 52 years old male patient Mr. MOHAMMAD ABDUL JALIL presented with c/o chest pain associated with profuse sweating since 1 day. On evaluation diagnosed as CAD -AWSTEMI, SEVERE LV DYSFUNCTION, CAG DONE SHOWED DVD, PRIMARY PTCA TO LAD DONE ON 21/07/22 AND INTERVAL PTCA TO LCX DONE ON 23/07/22. Good result. Patient asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
- 5) TAB. FLAVEDAN MR 35 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. NIKORAN 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 7) TAB. DYTOR PLUS 5 MG ONCE DAILY AT 8AM TO CONTINUE.

CONTINUE OWN DIABETIC MEDICATION

REVIEW AFTER 11 DAYS WITH CBC, RP-2, ECG

ARH1.0001154275

Name

Mr. S SHANKER

Patient Identifier

ARHIP56740

Age

49Yr
2Mth
25Days

Sex

Male

Date of Admission

22-Jul-2022

**Date of Discharge
MLC No**

Address

SA-2,KRISHNA COLONY,SHIVALAYAM
STREET,MANCHERIAL
DISTRICT,Luxettipet,Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no:SICU
3

Primary Consultant

Dr. KRISHNA CHAITANYA M

CAD UNSTABLE ANGINA
CAG- PATENT LAD STENT
MILD LV FUNCTION , SR

C/o chest discomfort, epigastric pain

S/P PTCA-LAD ON 30/04/2018

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 49 years old male patient Mr. SHEKAR presented with c/o chest discomfort, epigastric pain. On evaluation diagnosed as CAD UNSTABLE ANGINA, CAG- PATENT LAD STENT, MILD LV FUNCTION , SR. Managed conservatively. Patient asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

- 1) TAB. ROZAGOLD 10MG ONCE DAILY AT 8PM TO CONTINUE.
- 2) TAB. MET XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS WITH CBC, RP-2,

ARH1.0001201610

		Name	Mr. GOTIKAR SRINIVAS	
Patient Identifier	ARHIP56780	Age	52Yr 7Mth 22Days	
Sex	Male	Date of Admission	25-Jul-2022	
Date of Discharge				
MLC No				
Address	MANTHANI, PEDDAPALLY,Karimnagar,Telangana		Ward/ Bed No	First Floor, MICU, Bed no:MIC U 9
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal			

DYSELECTROLYTEMIA

C/o hiccups since 1 day, constipation
Generalised weakness,
Known case of hypertension

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 52 years old male patient Mr. GOTIKAR SRINIVAS came with c/o hiccups since 1 day, constipation, generalised weakness. All necessary investigations were done and diagnosed as DYSELECTROLYTEMIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1) TAB. RAZO-D ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

2) TAB. HEDNEURON ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233674

		Name	Mr. NARAYANA KURMA	
Patient Identifier	ARHIP56759	Age	61Yr 0Mth 2Days	
Sex	Male	Date of Admission	23-Jul-2022	
Date of Discharge				
MLC No				
Address	27-1-91, PEDDAMPET RAILWAY STATION, BELLAMPALLI,Mancheria, Telangana		Ward/ Bed No	First Floor, HDU, Bed no:HD U 2
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD)			

CORONARY ARTERY DISEASE , NSTEMI

MILD LV DYSFUNCTION,

CORONARY ANGIOGRAM DONE ON 23/07/2022 - CAD-TVD

C/o chest pain since 2 days

At Admission

Afebrile

PR: 80/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 61 years old male patient Mr. NARAYANA KURMA presented with complaint of chest pain on evaluation he was diagnosed as NSTEMI with mild LV dysfunction. CAG done showed triple vessel disease. Patient and family counselled about the need for CABG. Family wanted to come later hence, being discharged at request. Explained the need for early re-vascularisation

DISCHARGE MEDICATION:

1. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. PAN 40MG ONCE DAILY AT 8AM FOR 10 DAYS
6. TAB. CLOPILET A 75/25 ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. ATORVA 20 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AS EARLY AS POSSIBLE FOR CABG

ARH1.0001233626

Name	Mr. MALLAVVA THOTLA
Patient Identifier	ARHIP56753
Age	48Yr 0Mth 3Days
Sex	Male
Date of Admission	22-Jul-2022
Date of Discharge	
MLC No	
Address	DHOMALAKUNTA,PEGADAPALLI,JAGTIAL,Other,Telangana
Ward/Bed No	First Floor, MICU, Bed no:MICU 8
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY

CVA WITH ACUTE INFARCTS IN POSTERIOR CIRCULATION

C/o Weakness of right upper limb and lower limb, slurring of speech since 1 day
History of vomiting and giddiness present

AT ADMISSION:

Afebrile

PR: 66/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft, BS+

A 48 years old female patient MALLAVVA came with c/o weakness of right upper limb and lower limb, slurring of speech since 1 day, vomiting and giddiness present. All necessary investigations were done and diagnosed as CVA WITH ACUTE INFARCTS IN POSTERIOR CIRCULATION. Managed conservatively. On 25/07/2022 at 04.10 AM patient had sudden cardiac arrest, CPR done according to ACLS guidelines, patient was intubated with 7.5 mm ET tube and connected to mechanical ventilator support, patient reverted to normal sinus rhythm. Poor prognosis explained to patient attendants but patient attenders are requested to discharge hence patient discharged under LAMA, referred to Higher Centre for further management

ARH1.0001230254

Name

Mr.
SAMPATH
KUMAR S

Patient Identifier

ARHIP56749

Age

47Yr
3Mth
0Days

Sex

Male

**Date of
Admission**

22-Jul-
2022

**Date of Discharge
MLC No**

Address

CHIGURUMAMIDI,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 11

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE , NSTEMI

SEVERE LV DYSFUNCTION [EF-30%] SR

K/C/O CAD S/P PTCA TO LAD [03/22],

CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-LM+LCX

PLAN CABG.

C/o Shortness of breath on exertion since 1 day

At Admission

Afebrile

PR: 82/min

BP: 130/90 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 47 years old male patient Mr. SAMPATH KUMAR S came with c/o Shortness of breath on exertion since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE , NSTEMI, SEVERE LV DYSFUNCTION [EF-30%] SR, K/C/O CAD S/P PTCA TO LAD [03/22], CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-LM+LCX, PLAN CABG.. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. ALDACTONE 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001233523

Name	Mr. POTHULA KOMARAI AH		
Patient Identifier	ARHIP56715	Age	65Yr 0Mth 6Days
Sex	Male	Date of Admission	20-Jul-2022
Date of Discharge			
MLC No			
Address	6-4-75/7, IB COLONY, GODAVARIKANI, PEDDAPALLI, Karimnagar, Telangana	Ward/Bed No	Second Floor, Semi Private, Bed no:115C
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWM I

MILD LV DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 20/07/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD (Two stents), Proximal LAD with 3.5 X 18 MM XIENCE XPEDITION, mid LAD with 3.0 X 15 MM XIENCE XPEDITION DONE ON 20/07/2022

C/o chest pain since 10 days

AT ADMISSION:

Afebrile

PR: 70/min

BP: 170/100mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. POTHULA KOMARAI AH came with c/o chest pain since 10 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAMI, MILD LV DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 20/07/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD (Two stents), Proximal LAD with 3.5 X 18 MM XIENCE XPEDITION, mid LAD with 3.0 X 15 MM XIENCE XPEDITION DONE ON 20/07/2022. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. BRILINTA 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. TELMA 40 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
3. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) SYP. POTKLOR 15 ml TWICE DAILY AT 8AM AND 8PM

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

56731

ARH1.0001233566		Name	Mr. MOHAMMAD MOULANA
Patient Identifier	ARHIP56731	Age	70Yr 0Mth 5Days
Sex	Male	Date of Admission	21-Jul-2022
Date of Discharge			
MLC No			
Address	UPPARAMALYAL,Karimnagar,Telangana	Ward/Bed No	First Floor, HDU, Bed no:HDU12
Primary Consultant	Dr. KRISHNA CHAITANYA		

AWSTEMI - LATE PRESENTATION
MILD LV DYSFUNCTION
FC- III AOE
NO HF
SR
CAG, SVD (LAD)
S/P PCI TO LAD (2 STENTS)

History of chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70 years old male patient Mr. MOHAMMAD MOULANA came with history of chest pain. On evaluation ECG showed a Evolved AWMi. CAG done showed SVD with 2 lesions in LAD, PTCA to mid LAD with 3 x 24 mm stent and proximal LAD with a 3 x 28 mm stent. TIMI-III flow. Good result. Advised to stop smoking and be medication complaint, otherwise the risk of stent thrombosis explained to patient. He is asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET A 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
6. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. AMLODAC 5 MG ONCE DAILY AT 8AM TO CONTINUE.
8. 6. TAB. ALDACTONE 25 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2

ARH1.0001233582		Name	Mrs. NARSAVVA GANGI
Patient Identifier	ARHIP56730	Age	65Yr 0Mth 5Days
Sex	Female	Date of Admission	21-Jul-2022
Date of Discharge			
MLC No			
Address	THIRMALAPUR,Karimnagar,Telangana	Ward/Bed No	Second Floor, Female General Ward, Bed no:GW 6
Primary Consultant	DR. NIKHIL GOLI --NEUROLOGY		

ACUTE INTRAPARENCHYMAL BLEED WITH ACUTE INFARCT IN RIGHT MCA TERRITORY

C/o Weakness of left upper limb and lower limb since 4 days associated with slurring of speech

AT ADMISSION:

Afebrile

PR: 84/min

BP: 100/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 65 yrs old female patient Mrs. NARSAVVA GANGI came with c/o weakness of left upper limb and lower limb since 4 days associated with slurring of speech. All necessary investigations done and diagnosed as ACUTE INTRAPARENCHYMAL BLEED WITH ACUTE INFARCT IN RIGHT MCA TERRITORY. Managed conservatively. Now as the patient is

haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. LEVIPIL 500MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 2) SYP. LOOZ 2tsp ONCE DAILY AT 9PM
- 3) SYP. GLYCEROL 2tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM

REVIEW AFTER 11 DAYS TO DR NIKHIL GOLI SIR OPD

ARH1.0001233477

Name

Mr.
JALALUDDIN
MOHAMMED

Patient Identifier

ARHIP56762

Age

65Yr
0Mth
7Days

Sex

Male

Date of Admission 23-Jul-2022

Date of Discharge

MLC No

Address

5-2-102,OSMANPURA
STREET,JAGTIAL,Karimnagar,Telangan
a

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
7

Primary Consultant

Dr. KRISHNA CHAITANYA M

CAD, S/P CABG [LIMA- LAD, SVG- OM] 2011,
PTCA TO RCA [2002], NORMAL LV SYSTOLIC FUNCTION, LVEF -55%, NO HF SR
NOW, NSTEMI, CAG - LIMA - LAD PATENT,
SVG- OM OCCLUDED, LMCA 99% STENOSIS, RCA STENT MILD ISR, TOBACCO
CHRONIC DUODENAL ULCER, ANTRAL ULCER NO ACTIVE BLEEDING

History of chest pain

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 yrs old male patient Mr. JALALUDDIN MOHAMMED came with history of chest pain. He is a known case of CAD, S/P CABG (LIMA to LAD, SVG to OM, PTCA to RCA). On evaluation ECG showed significant ST depression and Trop-T significantly positive suggestive of NSTEMI. He was severely anaemic at the time of admission with haemoglobin of 7 g/dL. He also has a history of duodenal ulcer. Hence he was managed medically initially Gastroenterology

evaluation with upper GI scopy showed only antral ulcers and chronic duodenal ulcer with no active bleeding. After informed consent and explaining risk to family, he was taken up for CAG. CAG showed ostial LMCA 99% stenosis, LCx normal, LAD mid total occlusion. RCA stent patent with mild ISR. LIMA to LAD patent with good distal runoff. SVG to OM occluded. As blood flow to LCx is through LMCA, family was explained the need for PCI to protected LMCA. PTCA to LMCA done with 4 x 15 mm ONYX stent and post-dilated to 5 x 10 mm NC balloon. Good result, TIMI-III flow. Patient explained the need to stop smoking and risk of stent thrombosis and in stent restenosis. He is stable and asymptomatic at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. HP KIT FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP2

ARH1.0001233533

Name

Mr.
MALLAIAH
KYATHAM

Patient Identifier

ARHIP56722

Age

73Yr
0Mth
6Days

Sex

Male

Date of Admission

20-Jul-2022

**Date of Discharge
MLC No**

Address

POSANIPET, KATHALAPUR,
JAGITIAL,Karimnagar,Telangana

**Ward/
Bed No**

Second
Floor,
Male
General Ward,
Bed
no:GW
22

Primary Consultant

Dr. RAMCHANDER TORREM

CHRONIC KIDNEY DISEASE
HYPERKALAEMIA

C/o bilateral pedal oedema, shortness of breath and decreased urine output.

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 73 years old male patient Mr. MALLAIAH KYATHAM came with c/o bilateral pedal oedema, shortness of breath and decreased urine output. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE, HYPERKALAEMIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOCEF-CV **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. SOBINIX DS ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. RANTAC 150 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
4. TAB. KETOALFA **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. MULTI-8 ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. UBILIFE ONCE DAILY AT 2PM TO CONTINUE.
7. TAB. DYTOR PLUS 10/50 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO NEPHROLOGY OPD.

ARH1.0001233697

		Mrs. GURRAM RAJESWARAMMA	
Patient Identifier	ARHIP56774	Age	55Yr 0Mth 2Days
Sex	Female	Date of Admission	24-Jul-2022
Date of Discharge MLC No			
Address	KRISHNA COLONY,Mancherial,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MIC U 11
Primary Consultant	Dr Chandra Shekar Sathineni		

HAEMATEMESIS
? CSOM, UPPER GI BLEED

C/o Throat pain, dysphagia and nausea

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 55 years old female patient Mrs. GURRAM RAJESWARAMMA came with c/o throat pain, dysphagia and nausea. All necessary investigations were done and diagnosed as HAEMATEMESIS, ? CSOM, UPPER GI BLEED. Managed conservatively. Patient attendants requested for discharge, so patient is being discharged under LAMA. Referred to Higher Centre for further management.

ARH1.0001233571

Name

Mrs. M PADMA

Patient Identifier

ARHIP56726

Age

54Yr
0Mth
5Days

Sex

Female

Date of Admission

21-Jul-2022

Date of Discharge
MLC No

22-Jul-2022

Address

SIRICILLA,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MIC
U 5

Primary Consultant

Dr Chandra Shekar Sathineni(MD
(Internal Medicine))--INTERNAL
MEDICINE

Consultants

Surgeons

Anesthesiologists

Diagnosis
S

Diagnosis

Disease	Disease Type
LOWER RESPIRATORY TRACT INFECTION.	

LOWER RESPIRATORY TRACT INFECTION

C/o severe shortness of breath with a dry cough

Known case of carcinoma right breast, S/p mastectomy done 15 month back

AT ADMISSION:

Afebrile

PR: 150/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 54 years old female Mrs. PADMA patient presented with c/o severe shortness of breath with a dry cough. All necessary investigations done and diagnosed as LOWER RESPIRATORY TRACT INFECTION. Managed conservatively. On 22/07/22 at 4.10 pm patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 04.44 PM on 22/07/2022.

CAUSE OF DEATH: CARDIOPULMONARY ARREST SECONDARY TO LOWER RESPIRATORY TRACT INFECTION

ARH1.0001233511

Name Mr. PEDDULU
DASARI

Patient Identifier ARHIP56713

Age 63Yr 6Mth
7Days

Sex Male

Date of Admission 20-Jul-2022

Date of Discharge 24-Jul-2022
MLC No

Address 1-99,
NAGARAM,PEDDAPALLI,Karimnagar,Telanga
na

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU1
3

Primary Consultant Dr. Vidya Sagar A--CARDIOLOGY

Consultants
Anesthesiologi
sts

Surgeons Dr. Vidya Sagar A--CARDIOLOGY

☐ **Diagnosis**
S

Diagnosis

Disease	Disease Type
CAD-IWMI,MODERATE LV SYSTOLIC DYSFUNCTION(EF;38%)SR CAG(20/7/2022);CAD-TVD(LAD,LCX,RAMUS,RCA) PRIMARY PTCA+DES TO RCA(20/07/2022) R/F;HTN	

C/o chest pain since 2-3 days

At Admission

Afebrile

PR: 82/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 63 years old male patient Mr. PEDDULU DASARI came with c/o chest pain since 2-3 days. On evaluation diagnosed as CAD-IWMI, MODERATE LV SYSTOLIC DYSFUNCTION (EF; 38%) SR, CAG (20/7/2022); CAD-TVD (LAD, LCX, RAMUS, RCA), Primary PTCA + DES to RCA done. Patient is asymptomatic and being discharged in haemodynamically stable condition

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ROZAVEL 40 MG ONCE DAILY AT 9PM TO CONTINUE.
3. TAB. RANTAC 150 MG TWICE DAILY AT 7AM, 7PM FOR 10 DAYS.
4. TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. LIPRIL 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH CBC, RP2

ARH1.0001233489

Name

Mrs. FARZANA M

Patient Identifier

ARHIP56710

Age

54Yr
10Mth
2Days

Sex

Female

Date of Admission

20-Jul-2022

**Date of Discharge
MLC No**

Address

28-4-31 APSEB CALTEX BUS
STOP,Mancheria,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

Primary Consultant

Dr. KRISHNA CHAITANYA M

CAD -NSTEMI SEVERE LV DYSFUNCTION
PULMONARY OEDEMA
KILLIP CLASS-III
CARDIOGENIC SHOCK -RECOVERED
HF - RECOVERING
FC-II DOE
DIABETES MELLITUS

C/o dyspnea since 15 days

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 54 years old female patient Mrs. Farzana known diabetic presented with a history of worsening dyspnoea since 15 days. On evaluation, she was diagnosed to be in LV failure, she was started on IV diuretics, NIV and other acute HF regimen. She improved symptomatically and got stabilized. CAG done showed diffusely diseased LAD and LCx and

RCA has severe stenosis in the proximal and distal segments. Her anatomy is not suitable for bypass surgery, which was discussed today with her husband, only revascularisation of RCA is possible and this limited options clearly explained due to husband. PTCA to RCA done. TIMI-III flow, she was stable and in controlled. Heart failure status, her delicate situation of heart failure and possibility of acute decompensated heart failure and cardiogenic shock clearly explained to husband. Advised salt and fluid restriction.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
6. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. ALDACTONE 50 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. LASIX 40 MG 1 TAB AT 8AM, ½ TAB AT 2PM & 1 TAB AT 8PM CONTINUE.
9. TAB. ZORYL-M1 **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
11. SYP. POTKLOR 15 ml WITH GLASS OF WATER THRICE DAILY AT 8AM 2PM 8PM FOR 2 DAYS

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH CBC, RP2.

ARH1.0001232182

Name

Mr. S RAYAMALLU

Patient Identifier

ARHIP56417

Age

65Yr
1Mth
5Days

Sex

Male

Date of Admission

30-Jun-2022

Expired Date MLC No

20-Jul-2022

Address

RAMAKRISHNAPUR,
MANCHERAYAL,Telangana

Ward/ Bed No

First
Floor,
MICU,
Bed
no:MIC
U 9

Primary Consultant

DR. SRI KARAN UDDESH --INTERNAL

C/o generalised weakness, decreased urine output

AT ADMISSION:

PR: 120/min

BP: 110/60mmHg on Noredrenaline 15 ml/hr

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98% on NIV

P/A: Soft

GCS-10/15

A 65 year old male patient Mr. RAYAMALLU came with above mentioned complaints. Patient was taken over from Urology on 05/07/ 2022 after patient had undergone TURP and optical urethrotomy. Patient was drowsy, was in hypotension and was diagnosed to have sepsis with multiorgan dysfunction syndrome. Patient was started on INJ. MEROPENEM according to creatinine clearance. Blood cultures and urine cultures were sent. Patient was intubated in view of poor GCS. Blood culture was sterile urine culture showed growth and antibiotics were adjusted according to sensitivity. Patient continued to require mechanical ventilation. Patient recovered from hypotension and acute kidney injury. Despite broad spectrum antibiotics patient continued to have fever spikes . Patient was extubated on 13/07 /22. Was

maintaining saturation of 3 L/min of oxygen. On 14/07/22 in the night, patient's GCS dropped to 3 / 15 and he had paucity of limb movements an MRI brain revealed posterior circulation infarcts. A Neurologist consultation was taken and advice was followed. Patient was re intubated in view of poor GCS. Patient's urine output decreased nephrology consultation was taken and 2 cycles of SLED were done. Patient's condition did not improve with the above treatment. On 20/07/2022 patient had sudden cardiac arrest at 04.40 AM CPR was initiated according to ACLS protocol despite best efforts patient could not be revived and declared dead at 04.47 AM on 20/07/2022.

ARH1.0001133480		Name	Mrs. JERIPOTHULA SHASHIKALA
Patient Identifier	ARHIP56763	Age	56Yr 1Mth 6Days
Sex	Female	Date of Admission	23-Jul-2022
Date of Discharge			
MLC No			
Address	DURGAMMAGADDA,Karimnagar,Telangana	Ward/Bed No	First Floor, HDU, Bed no:HD U 6
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD)		

CORONARY ARTERY DISEASE
S/P PCI TO LAD AND LCX (2017)

C/o chest pain, breathing difficulty on exertion since 3 days

AT ADMISSION:

Afebrile

PR: 74/min

BP: 160/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100% on room air

P/A: Soft, BS+

A 56 years old female patient Mrs. JERIPOTHULA SHASHIKALA known case of CAD, S/P PCI to LAD and LCx presented with history of chest pain, breathing difficulty on exertion. CAG done showed patent LAD and LCx stents, mid LAD has 50% stenosis. She was planned for high intensity statin therapy and anti-anginal medication. She was symptomatically better and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ROSEDAY GOLD 20MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. VGM3 ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. MET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE
5. TAB. TELMA 40 MG ONCE DAILY AT 8AM TO CONTINUE
6. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
8. TAB. ANXIT 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH CBC, RP2.

ARH1.0001233722

Name	Mrs. RAJAMMA MODRAKOLA		
Patient Identifier	ARHIP56793	Age	64Yr 6Mth 2Days
Sex	Female	Date of Admission	25-Jul- 2022
Date of Discharge			
MLC No			
Address	2-22, GANGADHARA,Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU1 0
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE-IWSTEMI

MODERATE LV DYSFUNCTION

SEVERE MR, SR

R/F : HTN, DM, HYPOTHYROIDISM

PLAN : CAG

Anaemia : 1 Unit PCV transfusion done improved to Hb-10.5

C/o left sided chest pain, SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 64 years old female patient Mrs. RAJAMMA MODRAKOLA came with c/o left sided chest pain, SOB since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE-IWSTEMI, MODERATE LV DYSFUNCTION, SEVERE MR, SR, R/F : HTN, DM, HYPOTHYROIDISM, PLAN : CAG, Anaemia : 1 Unit PCV transfusion done improved to Hb-10.5. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RAMISTAR 1.25 MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. FRUSELAC ONCE DAILY AT 2PM TO CONTINUE.
6. TAB. THYRONORM 50 MCG ONCE DAILY AT 7AM BBF TO CONTINUE.
7. TAB. NEXPRO 20 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. ZORYL M1 ONCE DAILY AT 8AM TO CONTINUE.
9. CAP. VSL # ONCE DAILY AT 2PM TO CONTINUE.
10. ORS SACHETS THRICE DAILY AT 8AM 2PM 8PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001233720

Name

Mr. GOPAIAH T

Patient Identifier

ARHIP56826

Age

47Yr
0Mth
2Days

Sex

Male

Date of Admission

27-Jul-2022

**Date of Discharge
MLC No**

Address

RAJAKKAPETA,Siddipet,Telangana

**Ward/
Bed No**

First
Floor,
Day
Care,
Bed
no:D
C 6

Primary Consultant

Dr. KRISHNA CHAITANYA

CHEST PAIN
CAG-NORMAL CORONARIES
NORMAL LV FUNCTION
SINUS RHYTHM

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 78/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 100%

P/A: Soft

A 47 years old male patient ^{GOPAIAH} came with c/o chest pain. On evaluation diagnosed as CHEST PAIN, CAG - NORMAL CORONARIES, NORMAL LV FUNCTION, SINUS RHYTHM. Patient is being discharged in hemodynamically stable condition.

CONTINUE ANTIHYPERTENSIVE AND DIABETIC MEDICATION

ARH1.0001159171

Name

Mr. NARAYANA J

Patient Identifier

ARHIP56754

Age

54Yr
0Mth
3Days

Sex

Male

Date of Admission

23-Jul-2022

**Date of Discharge
MLC No**

Address

godavarikhani,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 3

Primary Consultant

Dr. KRISHNA CHAITANYA M (

CAD, NSTEMI, FAIR LV FUNCTION
NO HF, SR, SVD, PTCA TO LAD (2.5 X 32 MM)
GOOD RESULT
TIMI-III FLOW

C/o complaint of chest pain

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 54 years old male patient NARAYANA presented with complaint of chest pain. On evaluation diagnosed to have NSTEMI. CAG done showed mid LAD critical 99% stenosis. PTCA to LAD with 2.5 x 32 mm stent. Good result. TIMI-III flow. Patient explained the need to stop all Tobacco use and risk of stent thrombosis and ISR. He is asymptomatic and haemodynamically stable at discharge

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
6. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
8. TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & FBS/PLBS REPORTS

ARH1.0001233681

Name

Mr. ASHOK
MANKANI

**Patient
Identifier**

ARHIP56764

Age

56Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

23-Jul-
2022

**Date of
Discharge
MLC No**

Address

Other,Other

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 1

**Primary
Consultant**

Dr. KRISHNA CHAITANYA M

CAD AWMi (LYSED)
RESCUE PRIMARY PTCA TO LAD
SEVERE LV DYSFUNCTION
NO HF
SR

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 56 years old male patient Mr. ASHOK MANKANI presented with complaint of chest discomfort. On evaluation, diagnosed to have AAMI. He was thrombolised outside. Primary rescue PTCA done. Good result. He is haemodynamically stable and asymptomatic at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. LASIX 40 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. ALDACTONE 25 MG ONCE DAILY AT 2PM TO CONTINUE.
9. TAB. ZORYL M2 ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & FBS/PLBS REPORTS

ARH1.0001142424

Name		Mrs. BHUMAMMA SIRAVANI	
Patient Identifier	ARHIP56803	Age	38Yr 9Mth 7Days
Sex	Female	Date of Admission	25-Jul-2022
Date of Discharge			
MLC No			
Address	maruthinagar,Karimnagar,Telangana		Ward/ Bed No First Floor, HDU, Bed no:HD U 9
Primary Consultant	Dr. KRISHNA CHAITANYA M		

RHD
MILD MS - MODERATE MS
MODERATE MR
AF WITH FVR

C/o Palpitations, shortness of breath on exertion, generalised weakness

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 117/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 38 years old female patient Mrs. BHUMAMMA SIRAVANI presented with c/o Palpitations, shortness of breath. On evaluation, diagnosed to have RHD, MILD MS - MODERATE MS, MODERATE MR, AF WITH FVR. Admitted in view of AF with FVR . Rate control medications started. Symptomatically better, haemodynamically stable at discharge .

DISCHARGE MEDICATION:

1. TAB. DYTOR PLUS 10/50 MG 1 TAB AT 8AM, ½ TAB AT 8 PM TO CONTINUE.
2. TAB. PENTIDS 400 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ACITROM 1 MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NEUROBION FORTE ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. DIGOXIN 0.25 MG ½ TAB ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. METOPROLOL 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 1 MONTH TO CARDIAC OPD WITH CBC, RP2 REPORTS

ARH1.0001232544

Name

Mr.
PRABHAKAR
REDDY
KARIVEDA

Patient Identifier

ARHIP56815

Age

62Yr
3Mth
27Day
s

Sex

Male

**Date of
Admission**

26-Jul-
2022

**Date of Discharge
MLC No**

Address

H*NO
LAXMIDEVIPALLI, Karimnagar, Telangan
a

**Ward/Bed
No**

Secon
d
Floor,
Semi
Private
, Bed
no:103
B

Primary Consultant

Dr. SURESH GOUD S

Ca PROSTATE

SURGERY: TRUS GUIDED PROSTATE BIOPSY DONE ON 27/07/2022

C/o difficulty in micturition

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 62 yrs old male patient Mr. PRABHAKAR REDDY KARIVEDA came to the hospital with c/o difficulty in micturition. All necessary investigations done and diagnosed as Ca PROSTATE, SURGERY: TRUS GUIDED PROSTATE BIOPSY DONE ON 27/07/2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

1. TAB: CIFRAN 500 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: DOLO 650MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PAN 40MG ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS TO UROLOGY OPD

ARH1.0001233627

Name	Mr. RAMESH GULAPALLY		
Patient Identifier	ARHIP56751	Age	38Yr 0Mth 5Days
Sex	Male	Date of Admission	22-Jul-2022
Date of Discharge			
MLC No			
Address	BADDIPADAGA,NAGUNUR,SIDDIPET,Siddipet,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MICU 1
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, DVD [LAD, LCX]

PLAN CABG

MILD LV SYSTOLIC DYSFUNCTION, EF-45%

CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-DVD [LAD, LCX]

PLAN CABG WITH GRAFT TO LAD, OM.

C/o Giddiness, Blurring of vision, headaches and difficulty in walking since 2 days

Known case of CVA, hypertension
At Admission

Afebrile

PR: 81/min

BP: 120/80 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-96%

A 38 years old male patient ^{Mr. RAMESH GULAPALLY} came with c/o Giddiness, Blurring of vision, headaches and difficulty in walking since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, MILD LV SYSTOLIC DYSFUNCTION, EF-45%, CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-DVD [LAD, LCX], PLAN CABG WITH GRAFT TO LAD, OM. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. LIPRIN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. STAMLO 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS IN CARDIAC OPD

ARH1.0001233351

Name

Mr. M SRINIVAS

Patient Identifier

ARHIP56650

Age

42Yr
0Mth
12Days

Sex

Male

Date of Admission

16-Jul-2022

Date of Discharge
MLC No

16-Jul-2022

Address

NASPUR COLONY
MANCHRIAL ,Nirmal,Telangana

Ward/Bed No

First
Floor,
Day
Care,
Bed
no:DC
6

Primary Consultant


Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Surgeons

Dr. Vidya Sagar A--CARDIOLOGY

Anesthesiologists

 **Diagnosis**
S

Diagnosis

Disease	Disease Type
---------	--------------

CORONONARY ARTERY DISEASE ANTERIOR WALL MI.

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 75/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 42 years old male patient SRINIVAS came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONONARY ARTERY DISEASE ANTERIOR WALL MI. Managed conservatively. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

-
1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
 2. TAB. TONACT 10MG ONCE DAILY AT 2PM TO CONTINUE.
 3. TAB. RABIFORT 20MG ONCE DAILY AT 8AM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233700

		Mr. VENKATA NARAYANA NAGIRI	
Patient Identifier	ARHIP56779	Age	50Yr 11Mth 18Days
Sex	Male	Date of Admission	24-Jul-2022
Date of Discharge MLC No			
Address	KMR.LAXMIPETT,Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 8
Primary Consultant	Dr. KRISHNA CHAITANYA		

CORONARY ARTERY DISEASE, IWMI

THROMBOLYSED WITH TENECTEPLASE

SVD, MILD LV DYSFUNCTION
NO HF, SR

PTCA TO RCA DONE

C/o chest pain, sweatings since 2 days

AT ADMISSION:

Afebrile

PR: 75/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 50 years old male patient Mr. VENKATA NARAYANA NAGIRI presented with history of chest pain. He was initially evaluated at local hospital, as IWMi and thrombolised with Tenecteplase. Rescue PTCA to RCA done. Good result. TIMI-III flow. He was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
8. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & ECG

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233723

Name	Mr. MOHAMMAD JALEEL		
Patient Identifier	ARHIP56785	Age	61Yr 0Mth 3Days
Sex	Male	Date of Admission	25-Jul-2022
Date of Discharge			
MLC No			
Address	Chelgal Jagital,Karimnagar,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU3
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, ACUTE AWMI [WINDOW PERIOD : 4 hr]

MODERATE LV DYSFUNCTION, SR

K/C/O CAD, POST PTCA TO LAD (2015)

CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-DVD (LAD, RCA)

PRIMARY PTCA+DES TO LAD WITH 2.75 X 24 MM BIOFREEDOM DONE ON 25/07/2022
MEDICAL MANAGEMENT FOR RCA

R/F: HTN, DM1

C/o retrosternal chest pain radiating to the back associated with shortness of breath, vomitings (2 episodes)

AT ADMISSION:

Afebrile

PR: 58/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 100%

P/A: Soft

A 61 years old male patient Mr. MOHAMMAD JALEEL came with c/o retrosternal chest pain radiating to the back associated with shortness of breath, vomitings (2 episodes). All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE AAWMI [WINDOW PERIOD : 4 hr], MODERATE LV DYSFUNCTION, SR, K/C/O CAD, POST PTCA TO LAD (2015), CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-DVD (LAD, RCA), PRIMARY PTCA+DES TO LAD WITH 2.75 X 24 MM BIOFREEDOM DONE ON 25/07/2022, MEDICAL MANAGEMENT FOR RCA. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. AXCER 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. PROLOMET R 25/2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. GLYCOMET-SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 7) SYP. POTKLOR 15 ml THRICE DAILY AT 8AM, 2PM AND 8PM

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233703

Name

Mr. MURALI
KRISHNA N

**Patient
Identifier**

ARHIP56782

Age

28Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

25-Jul-
2022

**Date of
Discharge
MLC No**

Address

KMR GOPALPUR, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no: SICU
2

**Primary
Consultant**

Dr. GOUTHAM ROY

HEAD INJURY HEAD INJURY
FRACTURE RIGHT ZYGOMATIC ARCH, FRACTURE SACRUM
SURGERY: ORIF DONE ON 27.07.2022

Alleged history of slip and fall from first floor
History of LOC present
Laceration over the right supraorbital region

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 28 yr old male patient Mr. MURALI KRISHNA came with c/o alleged history of slip and fall from first floor, history of LOC present, laceration over the right supraorbital region. Maxillofacial Surgeon consultation taken, Surgery ORIF done for fracture right zygomatic arch. Findings: Laceration over right supraorbital and lateral wall of the orbit. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: METROGYL 400MG THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
3. TAB: ETOSHINE -MR ONCE DAILY AT 2PM FOR 5 DAYS.
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
5. TAB: FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 15 DAYS.
6. GLUTAVULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
7. TAB: CLAVUM 625 MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
8. TAB: ZERODOL TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
9. TAB. CHYMORAL FORTE THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS
10. TAB: GABANTIP AT 100/10 ONCE DAILY AT 8PM FOR 7 DAYS.
11. TAB: TOLPERITAS-D **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
12. SYP. SUCROFIL-O 2tsp THRICE DAILY AT 8AM, 2PM, 8PM FOR 15 DAYS.
13. MOUTH WASH THRICE DAILY

Review after 7 days in Maxillofacial Surgeon OPD for suture removal

Review after 7 days in General Surgery OPD.

ARH1.0001233755

Name

Mr. LACHANNA
KALLEM

**Patient
Identifier**

ARHIP56807

Age

73Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

25-Jul-
2022

**Date of
Discharge
MLC No**

Address

2-160, KASIPET, DANDEPALLI,
VELAGNUR,,Mancheria, Telangana

**Ward/
Bed No**

First
Floor,
SICU,
Bed
no: SICU
6

**Primary
Consultant**

Dr. GOUTHAM ROY

LEFT LOWER LIMB CELLULITIS

SURGERY: LEFT LOWER LIMB FASCIOTOMY DONE ON 26/07/2022

c/o left leg swelling, redness, pain since 3-4 days

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-80/min

BP-120/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 73 yr old male patient Mr. LACHANNA came with c/o left leg swelling, redness, pain since 3-4 days. All necessary investigations done and diagnosed as LEFT LOWER LIMB CELLULITIS, SURGERY: LEFT LOWER LIMB FASCIOTOMY DONE ON 26/07/2022.

Findings: Severely oedematous left lower limb with multiple blisters noted. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: CLINCIN 300MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: DYTOR PLUS 5 MG ONCE DAILY AT 8AM FOR 5 DAYS.
4. TAB: ROTAVALT THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.
5. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
6. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
7. TAB: ECOSPRIN AV 75/10 ONCE DAILY AT 8PM TO CONTINUE.
8. TAB: MET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

Review after 7 days in General Surgery OPD.

ARH1.0001233795

Name

Mr.
CHANDRAIAH
BELLI

Patient Identifier

ARHIP56814

Age

71Yr
0Mth
2Days

Sex

Male

Date of Admission 26-Jul-2022

Date of Discharge

MLC No

Address

GDK,Ramagundam,Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
2

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

CAD EVOLVED AWMI (late presentation)
MILD LV DYSFUNCTION (EF-45%)
NO HF
SR
CAG: TVD
PLAN CABG

C/o left sided chest pain, shortness of breath on exertion
History of bilateral pedal oedema
Known case of hypertension, diabetic mellitus

AT ADMISSION:

Afebrile

PR: 100/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 71 years old male patient Mr. CHANDRAIAH BELLI presented with history of chest pain, shortness of breath on exertion. On evaluation diagnosed to have CAD –EVOLVED AWMI (late presentation), MILD LV DYSFUNCTION (EF-45%), SR. Coronary angiogram done on 27/07/22 showed CAD - triple vessel disease. Plan CABG. Patient attenders were explained the need for CABG as earliest as possible. Patient complaint of burning micturition and increased frequency. USG abdomen showed grade III prostatomegaly, left renal parapelvic cyst (20 x 18 mm) with bilateral grade I renal parenchymal changes, CUE showed no pus cells, hence advised Urologist opinion. Patient attenders are willing for discharge hence discharged in haemodynamically stable condition at their request.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. DYTOR PLUS 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
7. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM 2PM 8PM
8. SYP. CITRALKAL 15 ML **TWICE IN A DAY AT 8 AM 8 PM**

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP2 & ECG

ARH1.0001233839		Name	Mr. NARSAIAH DASARI
Patient Identifier	ARHIP56837	Age	45Yr 0Mth 1Days
Sex	Male	Date of Admission	27-Jul-2022
Date of Discharge			
MLC No			
Address	MANDEPALLI, THANGALLAPALLI, RAJANNA SIRICILLA,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MIC U 2
Primary Consultant	DR. SRI KARAN UDDESH		

SEPTIC SHOCK WITH ACUTE KIDNEY INJURY

Complaints of vomiting, loose stools multiple episodes since 2 days
Known case of diabetes mellitus on regular medication

AT ADMISSION:

Patient is drowsy

Afebrile

PR: 120/min

BP: 70/ 40 mmHg on noradrenaline 8 ml/hr

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 90% on O2 8 Litr/min

P/A: Soft

A 45 years old male patient Mr. NARSAIAH DASARI presented with above-mentioned complaints. Patient was diagnosed to have septic shock with acute kidney injury. Patient was started on INJ.NOREDRENALIN, INJ. MEROPENEM according to creatinine clearance. Nebulisation DUOLIN INJ. Pan and IV fluids. 2 D Echo was done which revealed regional wall motion abnormality. Cardiologist consultation was taken and orders were followed. Patient is now being discharged against medical advice as attenders are unwilling for further treatment

ARH1.0001233841		Name	Mr. ANJIAIAH NYATHA
Patient Identifier	ARHIP56841	Age	48Yr 3Mth 17Days
Sex	Male	Date of Admission	28-Jul-2022
Date of Discharge			
MLC No			
Address	JAGITAL,Karimnagar,Telangana	Ward/ Bed No	First Floor, SICU, Bed no:SICU 5
Primary Consultant	DR. SUBRAT KUMAR SOREN		

BRAINSTEM BLEED

Alleged history of sudden fall at office on 26/07/22 around 10:30 a.m.
c/o headache

Known case of hypertension,
Denova diabetic mellitus

AT ADMISSION:

Patient is unconscious days, not responding to deep pain stimulus

PR: 86/min

BP: 140/90mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft,

A 48 years old male patient Mr. ANJIAIAH NYATHA came with alleged history of sudden fall at office on 26/07/22 around 10:30 AM after c/o headache. All necessary investigations were done and diagnosed as BRAINSTEM BLEED . Patient is unconscious days, not responding to deep pain stimulus, Patient was intubated with 7.5 mm endotracheal tube and connected to mechanical ventilator support. Poor prognosis is

planning to patient attendants, they want to discharge against medical advice, so patient is being discharged under LAMA.

ARH1.0001233836

Name

Mrs. D SAROJANA

Patient Identifier

ARHIP56834

Age

40Yr
0Mth
1Days

Sex

Female

Date of Admission

27-Jul-2022

**Date of Discharge
MLC No**

Address

mohanraopet, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 10

Primary Consultant

Dr. SURESH GOUD S(MS,

UROSEPSIS BILATERAL PYELONEPHRITIS

H/o low backache, pain abdomen, fever and burning micturition, vomitings since 10 days

AT ADMISSION:

PR: 80/min

BP: 130/90 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 40 years old female patient SAROJANA came with c/o low backache, pain abdomen, fever and burning micturition, vomitings since 10 days. All necessary investigations were done and diagnosed as UROSEPSIS, BILATERAL PYELONEPHRITIS. Managed conservatively. Plan for B/L DJ stent, but patient attendants are unwilling, they want to discharge against medical advice, so patient being discharged under LAMA.

ARH1.0001233748

Patient Identifier

ARHIP56791

Sex

Female

Date of Discharge

MLC No

Address

H.NO.14-
20,VIDYANAGAR,MANDAMARRI,MANCHERIA
L-9398287324,Telangana

Primary Consultant

Dr. Vidya Sagar A--

Name

Mrs.
NARSAMMA
ITHARAVENI

Age

55Yr 0Mth
3Days

**Date of
Admission**

25-Jul-
2022

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU1
1

CORONARY ARTERY DISEASE, UNSTABLE ANGINA,

NORMAL LV FUNCTION, SR

CORONARY ANGIOGRAM (27/07/2022) -CAD-Mild disease (LCx, LAD ectatic)
PLAN MEDICAL MANAGEMENT

R/F : HTN

C/o chest pain, sweating since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old female patient Mrs. NARSAMMA ITHARAVENI came with c/o chest pain, sweating since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NORMAL LV FUNCTION, SR, CORONARY ANGIOGRAM (27/07/2022) -CAD- Mild disease (LCx, LAD ectatic), PLAN MEDICAL MANAGEMENT. Patient complaint of headache, neurophysician consultation done and treated accordingly. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
3. CAP. DRISE 2000 K ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. CALCIMAX 500MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
6. TAB. NEXITO PLUS 5MG ONCE DAILY AT 8PM TO CONTINUE.
7. TAB. GRENIL 1 TAB SOS

REVIEW AFTER 7 DAYS TO CARDIAC OPD & NEUROPHYSICIAN OPD

ARH1.0001233724

Name	Mr. MALLAIAH VEMULA		
Patient Identifier	ARHIP56788	Age	24Yr 3Mth 3Days
Sex	Male	Date of Admission	25-Jul-2022
Date of Discharge			
MLC No			
Address	1-84, ROMPIKUNTA, PEDDAPALLI, Karimnagar, Telangana	Ward/ Bed No	First Floor, CICU , Bed no: CICU 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, AWTMI, SR

MODERATE LV DYSFUNCTION, [EF-40%]

CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-SVD (LAD)

PRIMARY PTCA+DES TO LAD WITH 4.0 X 24 MM 3V ASTRA DONE ON 25/07/2022
R/F: SMOKING

C/o chest pain since 3 days

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 24 years old male patient Mr. MALLAIAH VEMULA came with c/o chest pain since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMi, SR, MODERATE LV DYSFUNCTION [EF-40%], CORONARY ANGIOGRAM DONE ON 25/07/2022 - CAD-SVD (LAD), PRIMARY PTCA+DES TO LAD WITH 4.0 X 24 MM 3V ASTRA DONE ON 25/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRASUDOC 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS
- 6) SYP. POTKLOR 15 ML in glass of water THRICE DAILY AT 8AM 2PM 8PM FOR 3 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233698

Name

Mr.
RAVINDHER
PURATHULA

Patient Identifier

ARHIP56777

Age

41Yr
0Mth
5Days

Sex

Male

**Date of
Admission**

24-Jul-
2022

**Date of Discharge
MLC No**

Address

2-32/79
KAMMUNUR,Karimnagar,Telangana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU
4

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM)

CAD -IWMI, SVD, LCX PROXIMAL TOTAL OCCLUSION
MILD LV DYSFUNCTION
NO HF, SR, TOBACCO,
S/P PCI TO LCX

C/o chest pain on and off since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 100/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 41 years old male patient Mr. RAVINDHER PURATHULA presented with complaint of chest pain. On evaluation diagnosed to have IWMI. CAG done showed SVD, LCx thrombotic total occlusion. PTCA to LCx done. Good result. He was asymptomatic and haemodynamically stable at discharge

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. AZTOR 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
5. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
9. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 11 DAYS / SOS TO CARDIAC OPD WITH CBC, RP2

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233880

Name

Mr. T
KIRAN
KUMAR

Patient Identifier

ARHIP56851

Age

32Yr
0Mth
1Days

Sex

Male

**Date of
Admission**

28-Jul-
2022

**Date of Discharge
MLC No**

Address

Shivajainagar,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
3

Primary Consultant

Dr. KRISHNA CHAITANYA M (

RECURRENT PALPITATIONS
DOCUMENTED PSVT
GOOD LV FUNCTION
NO HF, SR

C/o palpitations, chest heaviness since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 120/80 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 32 years old male patient Mr. KIRAN KUMAR presented with history of persistent palpitations posturing for couple of hours. He was evaluated at the local hospital and diagnosed to have narrow complex tachycardia, reverted with intravenous ADENOSINE. He now improved with medication. He was started on oral verapamil for maintenance and advised EPS + RFA. He was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. CALAPTIN 40 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM TO CONTINUE.

REVIEW AFTER 7 DAYS / SOS TO CARDIAC OPD WITH CBC, RP2

ARH1.0001075091

Name

Mrs.
CH.SUCHITRA .

Patient Identifier

ARHIP56855

Age

36Yr
5Mth
18Days

Sex

Female

Date of Admission

28-Jul-2022

**Date of Discharge
MLC No**

Address

SUBHASH
NAGAR,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 9

Primary Consultant

Dr. KRISHNA CHAITANYA M

REST ANGINA FOR EVALUATION

C/o chest pain, chest heaviness since 1 day

AT ADMISSION:

Afebrile

PR: 92/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 36 years old female patient Mrs. SUCHITRA presented with complaint of chest discomfort. On evaluation, ECG showed 'T' wave inversion II, III avF and early repolarisation changes V2. Trop 1, Trop T was negative.

Serial ECG's done showed no significant changes. She was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1.TAB. PANTOCID 40 MG ONCE DAILY AT 7AM [BEFORE FOOD] FOR 7 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001233707		Name	Mrs. NEERATI BADRAMMA
Patient Identifier	ARHIP56796	Age	62Yr 0Mth 4Days
Sex	Female	Date of Admission	25-Jul-2022
Date of Discharge			
MLC No			
Address	SINGAPUR,Huzurabad,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU 5
Primary Consultant	Dr. KRISHNA CHAITANYA		

LEFT SUBCLAVIAN STEAL SYNDROME CAG (28/07/2022) CHRONIC TOTAL OCCLUSION OF LEFT SUBCLAVIAN ARTERY

Complaints of left upper limb claudication and giddiness since 2 months

AT ADMISSION:

Afebrile

PR: 75/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 62 years old female patient Mrs. NEERATI BADRAMMA presented with complaint of left upper limb claudication and giddiness since 2 months. On evaluation diagnosed as left subclavian steal syndrome. Peripheral angiogram

done on 28/07/22 showed chronic total occlusion of left subclavian artery. Advised Vascular Surgeon consultation. Patient attenders explained the need for revascularisation. Patient is discharged in haemodynamically stable condition.

Review for Vascular Surgeon consultation on Tuesday 02/08/2022

ARH1.0001133015

Name

Mrs.
KHURSHEED

Patient Identifier

ARHIP56839

Age

58Yr
1Mth
14Days

Sex

Female

Date of Admission 27-Jul-2022

Date of Discharge
MLC No

Address

8 INCLINE
COLONY,Karimnagar,Telangana

Ward/Bed No

First
Floor,
HDU,
Bed
no:HD
U 1

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR
NORMAL LV FUNCTION [EF-60%]
CORONARY ANGIOGRAM (28/07/2022) -Mild LAD disease
PLAN MEDICAL MANAGEMENT
R/F : HTN, DM, HYPOTHYROIDISM

C/o left sided chest pain, mild sweatings since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 58 years old female patient Mrs. KHURSHEED came with c/o left sided chest pain, mild sweatings since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, NORMAL LV FUNCTION [EF-60%], CORONARY ANGIOGRAM (28/07/2022) -Mild LAD disease, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. NOVASTAT 40MG ONCE DAILY AT 8PM AFTER FOOD TO CONTINUE.
4. TAB. NICARDIA RETARD 20MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. TELMA H 80MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. METFORMIN SR 500MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. THYROXINE 25MCG ONCE DAILY AT 8AM TO CONTINUE.
8. SYP. POTKLOR 15 ML in $\frac{1}{2}$ glass of water **TWICE IN A DAY AT 8 AM 8 PM** FOR 3 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001233867

Name

Mrs. G
VAJRAMMA

Patient Identifier

ARHIP56849

Age

68Yr
0Mth
1Days

Sex

Female

Date of Admission

28-Jul-
2022

Date of Discharge**MLC No****Address**

GODAVARIKHANI,Telangana

Ward/Bed No

First
Floor,
SICU,
Bed
no:SICU
6

Primary Consultant

Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY

Consultants

Surgeons

Dr. GOUTHAM ROY (MS(General Surgery),Consultant General Surgeon)--GENERAL SURGERY

Anesthesiologists

Diagnosi

Diagnosis

Add Diagnosis

ARHIP56849

ARH1.000123386

—

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
2ND TOE DISARTICULATION RT	28-Jul-2022 17:00:00			

RIGHT 2nd TOE WET GANGRENE

SURGERY: RIGHT 2nd TOE DISARTICULATION DONE ON 28/07/2022

Complaint of pain and swelling over non-healing wound of 2nd Toe of right foot

H/o Denovo diabetes mellitus

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-90/min

BP-140/80mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 68 yr old female patient Mrs. VAJRAMMA came with c/o pain and swelling over non-healing wound of 2nd Toe of right foot. All necessary investigations done and diagnosed as RIGHT 2nd TOE WET GANGRENE, SURGERY: RIGHT 2nd TOE DISARTICULATION DONE ON 28/07/2022. Findings: 2nd Toe inter-phalangeal joint osteomyelitis wet native gangrene changes. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: CLINCIN 300MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: CIPLOX 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
3. TAB: PLETOZ 100 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 1 MONTH.
4. TAB: ULTRACET THRICE DAILY AT 8AM, 2PM, 8PM FOR 5 DAYS.
5. TAB: ND Q10 ONCE DAILY AT 2PM FOR 5 DAYS.
6. TAB: ECOSPRIN AV 75/10 ONCE DAILY AT 8AM FOR 1 MONTH.
7. TAB: ZORYL M1 ONCE DAILY AT 8AM FOR FOR 1 MONTH.

Review after 7 days in General Surgery OPD.

ARH1.0001233750

Name

Mr. CH
SHANKARAIAH

Patient Identifier

ARHIP56832

Age

60Yr 0Mth
4Days

Sex

Male

**Date of
Admission**

27-Jul-2022

**Date of Discharge
MLC No**

Address

Kothapalli, Karimnagar, Telangana

**Ward/Bed
No**

First Floor,
RECOVERY
ROOM, Bed
no:RR 8

Primary Consultant

Dr. GOUTHAM ROY

ACUTE FISSURE IN ANO WITH INTERNAL HAEMORRHOIDS SURGERY: LORD'S DILATATION, LATERAL SPHINCTEROTOMY+ HEMORRHOIDECTOMY DONE ON 28/07/2022

C/o per rectum bleeding, mild constipation since 1 month

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-82/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-100%

A 60 yrs old male patient Mr. CH SHANKARAI AH came with c/o per rectum bleeding, mild constipation since 1 month. All necessary investigations done and diagnosed as ACUTE FISSURE IN ANO WITH INTERNAL HAEMORRHOIDS, SURGERY: LORD'S DILATATION + LATERAL SPHINCTEROTOMY + HEMORRHOIDECTOMY DONE ON 28/07/2022. Findings: 7'O clock internal hemorrhoids noted (grade-III), Posterior fissure with severe spasm. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

Discharge Medication:

1. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
2. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
3. GLUTAVULT -V SACHETS ONCE DAILY AT 8AM WITH GLASS OF WATER FOR 15 DAYS.
4. SYP. LACTIHEP 3 TSP ONCE IN A DAY AT 8 PM
5. XYLOCAINE JELLY EVERY 4th hrly
6. METROGYL-P OINTMENT L/A THRICE DAILY AT 8AM 2PM 8PM
7. SITZ BATH TWICE DAILY

Review after 7 days in General Surgery OPD.

ARH1.0001233835

Name	Mr. J RAMASWAMY
Patient Identifier	ARHIP56831
Age	60Yr 0Mth 2Days
Sex	Male
Date of Admission	27-Jul-2022
Date of Discharge	
MLC No	
Address	KARIMNAGAR, Karimnagar, Telangana
Ward/ Bed No	First Floor, RECOVERY ROOM, Bed no:RR 5
Primary Consultant	Dr. GOUTHAM ROY (

LEFT GYNAECOMASTIA

SURGERY: LEFT SUBCUTANEOUS MASTECTOMY DONE ON 28/07/2022.

SURGERY: LEFT POST HEMATOMA EVACUTION DONE ON 28/07/2022.

Complaint of swelling of left breast

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-87/min

BP-110/70mmhg

RR-20/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 60 yrs old male patient Mr. RAMASWAMY came with c/o swelling of left breast. All necessary investigations done and diagnosed as LEFT GYNAECOMASTIA, SURGERY: LEFT SUBCUTANEOUS MASTECTOMY DONE ON 28/07/2022. Findings: Large glandular tissue noted in the left breast. LEFT POST HEMATOMA EVACUATION DONE ON 28/07/2022. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ZERODOL-SP TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ROTAVALT THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
4. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
5. TAB: FAMOCID 40 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001233691

Name

Mrs.
NASEEM
BEGUM

Patient Identifier

ARHIP56771

Age 67Yr 0Mth
5Days

Sex

Female

Date of Admission 24-Jul-2022

Date of Discharge
MLC No

Address

HUSSAINIPURA,Karimnagar,Telangana

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU1
3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, ACUTE IWMI,

CHB, MODERATE LV SYSTOLIC DYSFUNCTION, SR

KNOWN CASE OF CAD CAG (02/02/21) -TVD PLAN CABG

CORONARY ANGIOGRAM (24/07/2022) -TVD

PRIMARY PTCA TO RCA AND LCX AND TPI DONE ON 24/07/2022

ANAEMIA 1 UNITS PCV TRANSFUSION DONE

R/F - HTN, DM, HYPOTHYROIDISM

C/o chest pain since 3-4 hours associated with shortness of breath,

AT ADMISSION:

Patient unresponsive to commands

PR: 85/min

BP: Not recordable

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 86% on 15 Litr O2

P/A: Soft

A 67 years old female patient Mrs. NASEEM BEGUM came with c/o chest pain since 3-4 hours associated with shortness of breath. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, ACUTE IWMI, CHB, MODERATE LV SYSTOLIC DYSFUNCTION, SR, KNOWN CASE OF CAD CAG (02/02/21) -TVD PLAN CABG, CORONARY ANGIOGRAM (24/07/2022) -TVD, PRIMARY PTCA TO RCA AND LCX AND TPI DONE ON 24/07/2022, ANAEMIA 1 UNITS PCV TRANSFUSION DONE. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. PRAX 10MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. STORVAS 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) INJ HUMAN MIXTARD 30/70 30 U S/C AT 8AM, 15 U S/C AT 8PM TO CONTINUE.
- 5) TAB. PANTOCID 40 MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
- 6) TAB. LIVOGEN ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233704

Name

Mr. G
LAXMINARAYANA

**Patient
Identifier**

ARHIP56821

Age

50Yr
0Mth
4Days

Sex

Male

**Date of
Admission**

26-Jul-
2022

**Date of
Discharge
MLC No**

Address

Lingampet,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
7

**Primary
Consultant**

Dr. KRISHNA CHAITANYA

CORONARY ARTERY DISEASE, OLD AWM

MODERATE LV DYSFUNCTION
LMCA DISTAL 50% STENOSIS
LAD OSTIAL TOTAL OCCLUSION
RCA 95% STENOSIS
LCX NORMAL

Complaint of chest discomfort since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 50 years old male patient Mr. G LAXMINARAYANA came with complaint of chest discomfort. On evaluation he has moderate LV dysfunction with LVEF 40%. CAG done showed distal LMCA 60%, LAD proximal total occlusion, RCA proximal to mid 95% stenosis. He was stable and asymptomatic. He was advised to continue medication. He is advised CABG. He is being discharged with following advice.

DISCHARGE MEDICATION:

1. TAB. ROZAGOLD 20MG ONCE DAILY AT 8PM TO CONTINUE.
2. TAB. MET XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 2 PM** TO CONTINUE.
5. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. PAN 40MG ONCE DAILY AT 8AM FOR 10 DAYS

7. CONTINUE DIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH CBC, RP-2, FBS&PLBS REPORTS

ARH1.0001228912

Name

Mr. NEELAIAH
PONNAMALLA

**Patient
Identifier**

ARHIP56802

Age

58Yr
4Mth
14Days

Sex

Male

**Date of
Admission**

25-Jul-
2022

**Date of
Discharge
MLC No**

Address

Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
HDU,
Bed
no:HD
U 10

**Primary
Consultant**

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], SR

CORONARY ANGIOGRAM DONE ON 27/07/22

1. PATENT STENT IN LAD,
2. MILD ISR IN DISTAL LCX

PLAN MEDICAL MANAGEMENT

KNOWN CASE OF CAD - S/P PTCA + DES TO LAD & LCX DONE ON
17/03/22

R/F: HTN, DM

C/o chest pain since 2 days

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 58 years old male patient Mr. NEELIAIAH PONNAMALLA came with c/o chest pain since 2 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SEVERE LV SYSTOLIC DYSFUNCTION [EF-30%], SR, CORONARY ANGIOGRAM DONE ON 27/07/22, 1. PATENT STENT IN LAD, 2. MILD ISR IN DISTAL LCX, PLAN MEDICAL MANAGEMENT. KNOWN CASE OF CAD - S/P PTCA + DES TO LAD & LCX DONE ON 17/03/22. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. CONCOR 2.5 MG ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. FRUSELAC 25/50 ONCE DAILY AT 2PM TO CONTINUE.
- 6) TAB. GEMER-1 500/1 ONCE DAILY AT 8AM TO CONTINUE.
- 7) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001233838

Name

Mrs. LAXMI
KATAKAM

Patient Identifier

ARHIP56835

Age

64Yr 0Mth
3Days

Sex

Female

**Date of
Admission**

27-Jul-
2022

**Date of Discharge
MLC No**

Address

H.NO:1-
27/1,KISTAMPET,RAIKAL,JAGITAIL,Other,Telanga
na

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU1
2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, AWMI,

SEVERE LV DYSFUNCTION, SR

CORONARY ANGIOGRAM DONE ON 27/07/2022 - CAD-SVD (LAD)

PRIMARY PTCA TO LAD (2 STENTS) PROXIMAL LAD WITH PRONOVA CC 3.0 X 23 mm,
OSTIAL LAD WITH PRONOVA CC 3.0 X 13 mm DONE ON 27/07/2022

R/F: HTN

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 64 years old female patient Mrs. LAXMI KATAKAM came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWMI, SEVERE LV DYSFUNCTION, SR, CORONARY ANGIOGRAM DONE ON 27/07/2022 - CAD-SVD (LAD), PRIMARY PTCA TO LAD (2 STENTS) PROXIMAL LAD WITH PRONOVA CC 3.0 X 23 mm, OSTIAL LAD WITH PRONOVA CC 3.0 X 13 mm DONE ON 27/07/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. TONACT 40MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. RANTAC 150MG TWICE DAILY AT 8AM 8PM FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233800

Name

Mr.
LAXMINARAYANA
GARSHAKURTHI

Patient Identifier

ARHIP56827

Age

66Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

27-Jul-
2022

**Date of Discharge
MLC No**

Address

5-81
GANNERVARAM,Karimnagar,Telangan
a

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
1

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

CORONARY ARTERY DISEASE; IWMI

NORMAL LV FUNCTION

DVD, NO HF, SR

PRIMARY PTCA TO LCX AND PTCA TO LAD DONE

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 72/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 66 years old male patient Mr. LAXMINARAYANA GARSHAKURTHI presented with complaint of chest pain. On evaluation, he was diagnosed to be IWSTEMI. CAG done showed DVD. Primary PTCA to LCx and PTCA to LAD done. Good result. TIMI III flow. Patient is asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. FLAVEDON MR 35MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. AMLODAC 5 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. GLYCOMET SR 500 MG ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & FBS, PPBS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001162401

Name

Mrs.
RAVIKANTI
SUSHEELA

Patient Identifier

ARHIP56853

Age

73Yr
10Mth
23Days

Sex

Female

Date of Admission

28-Jul-2022

**Date of Discharge
MLC No**

Address

ntpc,ramangundam,peddapally,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 2

Primary Consultant

Dr Chandra Shekar Sathineni

NEUROGLYCOPENIA
DIABETIC MELLITUS
LV DYSFUNCTION
HYPERTENSION

c/o drowsiness, profuse sweating since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 73 years old female patient Mrs. RAVIKANTI SUSHEELA came with c/o drowsiness, profuse sweating since 1 day. All necessary investigations were done and diagnosed as NEUROGLYCOPENIA, DIABETIC MELLITUS, LV DYSFUNCTION, HYPERTENSION. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 2PM FOR 7 DAYS
2. TAB. CARDIVAS 6.25 MG TWICE DAILY AT 8AM AND 8PM FOR 7 DAYS
3. TAB. ECOSPRIN GOLD 10 MG ONCE DAILY AT 2PM FOR 7 DAYS
4. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
5. TAB. SARTEL 20 MG ONCE DAILY AT 2PM FOR 7 DAYS
6. TAB. DAPAKEY 5 MG ONCE DAILY AT 2PM FOR 7 DAYS
7. INJ. LANTUS 10 Units ONCE DAILY AT 8PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

APH1.0001151100

Name

Mr.
KOMARAIHAH
VANGA

Patient Identifier

ARHIP56877

Age

59Yr 0Mth
3Days

Sex

Male

**Date of
Admission**

30-Jul-
2022

**Date of Discharge
MLC No**

Address

h.no:8-6-403, bhaghat singh nagar,
godavarikhani,ramagundem,,Karimnagar,Tel
angana

**Ward/Bed
No**

First
Floor,
CICU ,
Bed
no:CICU1
3

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CORONARY ARTERY DISEASE, UNSTABLE ANGINA

NORMAL LV FUNCTION, SR

LEFT LEG CELLULITIS

K/C/O CAD, S/P CABG (2017)

R/F HTN, DM

C/o shortness of breath since 15 days

At Admission

Afebrile

PR: 87/min

BP: 160/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-97%

A 59 years old male patient Mr. KOMARAI AH VANGA came with c/o shortness of breath since 15 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, NORMAL LV FUNCTION, SR, LEFT LEG CELLULITIS, K/C/O CAD, S/P CABG (2017). Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. BETALOC 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. ATORVAS 80MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. REMISTAR 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001006482

Name

Mrs.
DUBBAKA
M
POCHAVVA

Patient Identifier

ARHIP56806

Age

65Yr
2Mth
25Days

Sex

Female

**Date of
Admission**

25-Jul-
2022

**Date of Discharge
MLC No**

Address

9-1-108, MALLIAL,Karimnagar,Andhra
Pradesh

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
2

Primary Consultant

Dr. KRISHNA CHAITANYA M

COMPLETE HEART BLOCK,

S/P VVI (2011)

C/o complaints of giddiness since 1 day

AT ADMISSION:

Afebrile

PR: 86/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 65 years old female patient Mrs. DUBBAKA M POCHAVVA presented with complaints of giddiness on evaluation she is a case of COMPLETE HEART BLOCK, S/P VVI (2011). Now end of life with battery and RV lead displaced in RV inflow. Hence, a new RV lead positioned at RV apex and PG connected good parameters and flouroscopic position. She was asymptomatic and stable of discharge.

DISCHARGE MEDICATION:

1. TAB. TELMA AM 40/5 ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. ANXIT 0.25 MG ONCE DAILY AT 8PM FOR 5 DAYS
3. TAB. DOLO 500 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

REVIEW AFTER 11 DAYS FOR SUTURE REMOVAL

ARH1.0001027714

Name	Mr. KASHAIAH GADDI
Patient Identifier	ARHIP56817
Sex	Male
Date of Discharge	
MLC No	
Address	GAMBIRAOPETA MALLUPALLY,Karimnagar,Andhra Pradesh
Primary Consultant	Dr. KRISHNA CHAITANYA

Age 54Yr
11Mth
3Days

Date of Admission 26-Jul-2022

Ward/ Bed No First Floor, CICU , Bed no:CICU 7

CORONARY ARTERY DISEASE, S/P PCI TO LCX + RCA

SEVERE LV DYSFUNCTION

NOW, FC III DOE, HF, RECOVERED

CAG-LAD mid 99% STENOSIS

S/P PTCA TO LAD DONE

CONTROLLED HF, SR

HYPOTHYROIDISM

C/o chest pain, sweatings since 1 day

AT ADMISSION:

Afebrile

PR: 50/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 54 years old male patient Mr. KASHAIAH GADDI presented with complaint of chest pain, sweatings since 1 day. He was diagnosed as CORONARY ARTERY DISEASE, S/P PCI TO LCX + RCA. Rescue PTCA to LAD done. Good result. TIMI-III flow. He was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ROSUVAS 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. MET XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. DYTOR PLUS 10 MG 1 TAB AT 8AM & ½ TAB AT 8PM FOR 10 DAYS.
8. TAB. RANTAC 150 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS
 1. TAB. MET XL 50MG ONCE DAILY AT 8AM TO CONTINUE.
 2. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
 3. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 2 PM** TO CONTINUE.
 4. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
 5. TAB. PAN 40MG ONCE DAILY AT 8AM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & ECG

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233970

Name

Mrs. CH RANI

Patient Identifier

ARHIP56881

Age

45Yr
0Mth
0Days

Sex

Female

Date of Admission

30-Jul-2022

**Date of Discharge
MLC No**

Address

B-148,RFCCL
TOWNSHIP,Ramagundam,Telangana

**Ward/
Bed No**

First
Floor,
Day
Care,
Bed
no:D
C 1

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD)

NON-SPECIFIC 'T' WAVE CHANGES IN ECG
CAG FOR RISK STRATIFICATION: NORMAL CORONARIES

H/o asymptomatic, outside trop-T positive

AT ADMISSION:

Afebrile

PR: 89/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 45 years old female patient Mrs. CH RANI no co-morbidities was asymptomatic. On routine evaluation ECG showed non-specific ECG changes in periodical leads, wanted CAG for risk stratification. CAG done is normal. She is being discharged with following advice.

ARH1.0001230254

Name

Mr.
SAMPATH
KUMAR S

Patient Identifier

ARHIP56809

Age

47Yr
3Mth
7Days

Sex

Male

**Date of
Admission**

26-Jul-
2022

**Date of Discharge
MLC No**

Address

CHIGURUMAMIDI, Karimnagar, Telangana

**Ward/
Bed No**

First
Floor,
CT
POST,
Bed
no:CT
5

Primary Consultant

Dr SOMASHEKAR K(MS)

CORONARY ARTERY DISEASE +NSTEMI+ LMCA+DOUBLE VESSEL DISEASE +
SEVERE LV DYSFUNCTION+S/P PTCA TO LAD, RENAL DYSFUNCTION

SURGERY - EMERGENCY CORONARY ARTERY BYPASS GRAFTING [LIMA TO
LAD, SVG TO OM] DONE ON 27/07/2022.

C/o chest pain a/w SOB since 3 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-80/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 47 years old male patient Mr. SAMPATH KUMAR presented to hospital with c/o chest pain a/w SOB since 3 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + NSTEMI+LMCA+DOUBLE VESSEL DISEASE + SEVERE LV DYSFUNCTION+S/P PTCA TO LAD, RENAL DYSFUNCTION. SURGERY - EMERGENCY CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM] DONE ON 27/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED DILATED LV, SEVERE LV DYSFUNCTION, MILD AR, EF-30%

BMI is 23.1 kg/m².

Sr. Creatinine report on 28.07.2022 1.8 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR 10MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 5) TAB. PROLOMET XL 25 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 7) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9PM FOR 5 DAYS.
- 8) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.
- 9) TAB. DOLO 650 MG THRICE IN A DAY AT 8 AM, 2 PM & 8 PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001233003

Name	Mr. KUSA VENKAT NARSAIAH
Patient Identifier	ARHIP56810
Age	83Yr 0Mth 26Days
Sex	Male
Date of Discharge	26-Jul-2022
MLC No	
Address	NEELOZIPALLI BOINPALLI,Karimnagar,Telangana
Ward/Bed No	First Floor, MICU, Bed no:MICU 4
Primary Consultant	Dr Chandra Shekar Sathineni(MD)

METABOLIC ENCEPHALOPATHY
TYPE-II RESPIRATORY FAILURE

C/o sudden onset of shortness of breath since 1 hour

Known case of hypertension, bronchial asthma

AT ADMISSION:

PR: 93/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 95%

P/A: Soft,

A 83 years old male patient Mr. KUSA VENKAT NARSAIAH came with c/o sudden onset of shortness of breath since 1 hour. All necessary investigations were done and diagnosed as METABOLIC ENCEPHALOPATHY, TYPE II RESPIRATORY FAILURE. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PANTOCID-L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 4) TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 5 DAYS
- 5) TAB. HEADNEURON ONCE DAILY AT 8PM FOR 10 DAYS
- 1) TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. LINOZEM 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001234009		Name	Mr. CHANDRAMOUL I KAMMORI
Patient Identifier	ARHIP56894	Age	51Yr 0Mth 1Day s
Sex	Male	Date of Admission	31- Jul- 2022
Date of Discharge			
MLC No			
Address	H.NO:11- 90,HUZURABAD,KARIMNAGAR,Telanga na	Ward/Bed No	First Floor, Day Care, Bed no:D C 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA
 MODERATE LV SYSTOLIC DYSFUNCTION [EF -35%]
 CORONARY ANGIOGRAM DONE ON 31/01/2022 - CAD-LM+TV D [LAD, LCX, RCA]

PLAN: CABG WITH GRAFT TO LAD, OM, RAMUS & PDA

C/o left sided chest pain a/w shortness of breath since 5 days

At Admission

Afebrile

PR: 70/min

BP: 130/70 mmHg

RR-20/min

RS: BAE+

CVS: S1S2

P/A: Soft

SPO2-98%

A 51 years old male patient ^{Mr. CHANDRAMOULI KAMMORI} came with c/o left sided chest pain a/w shortness of breath since 5 days. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, UNSTABLE ANGINA, MODERATE LV SYSTOLIC DYSFUNCTION [EF -35%], CORONARY ANGIOGRAM DONE ON 31/01/2022 – CAD-LM+TVD [LAD, LCX, RCA], PLAN: CABG WITH GRAFT TO LAD, OM, RAMUS & PDA. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. NOVASTAT 40 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. MONIT GTN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. CONCOR COR 2.5 MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. LOSAR 25 MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 7 DAYS IN CARDIAC OPD

ARH1.0001157553		Name	Mrs. MAHAMAD FATEEMA
Patient Identifier	ARHIP56770	Age	69Yr 1Mth 5Days
Sex	Female	Date of Admission	24-Jul-2022
Expired Date	30-Jul-2022		
MLC No			
Address	1-75, REPAKA, ELLANTHAKUNTA, KARIMNAGAR, Karimnagar, Telangana	Ward/Bed No	First Floor, CT POST, Bed no:CT 1
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY	Consultants	
Surgeons	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-	Anesthesiologists	Dr. K.S.D.KRISHNA KIRAN--

Diagnosis

Diagnosis

[Add Diagnosis](#)

Disease	Disease Type
---------	--------------

Diagnosis: CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P PTCA TO LAD & LCX, DM+HTN+S/P AWM

Surgery: CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] + IABP DONE ON 28/07/2022

C/o Retrosternal chest pain, radiating to back since 1 day

ON ADMISSION

Pt is drowsy.

Afebrile

PR-81/min

BP-120/80mmhg

RR-20/min

RS-BAE+,

CVS-S1S2+

P/A-Soft

SPO2-98%

A 69 years old female patient Mrs. MAHAMAD FATEEMA presented to hospital with c/o retrosternal chest pain, radiating to back since 1 day. All necessary investigations were done and diagnosed as **Diagnosis:** CORONARY ARTERY DISEASE + TRIPLE VESSEL DISEASE + S/P PTCA TO LAD & LCX, DM+HTN+S/P AWTMI, **Surgery:** CORONARY ARTERY BYPASS GRAFTING [SVG TO LAD, OM] + IABP DONE ON 28/07/2022. On 30/07/2022 Patient went to bradycardia. CPR started according to ACLS guidelines. Inj.Adrenaline & Inj Atropine given, but patient not revived, then 3 cycles of CPR done Inj.Adrenaline & Inj Atropine repeated, CPR continued. Patient not revived. Despite efforts, patient could not be revived back, rhythm was asystole, ECG showed flat lines, Pupils-b/l dilated and fixed. Hence patient was declared as dead at 3.36 PM.

CAUSE OF DEATH:

CARDIOPULMONARY ARREST SECONDARY TO LOW CARDIAC OUTPUT FAILURE, S/P CABG, POD-2, CAD-NSTEMI, TVD, SEVERE LV DYSFUNCTION, HTN, DM, OBESITY.

ARH1.0001234001

Name

Mrs.
JEEVITHA T

Patient Identifier

ARHIP56888

Age 72Yr 0Mth
3Days

Sex

Female

Date of Admission 30-Jul-2022

Date of Discharge
MLC No

Address

4-1-262, KORUTLA,
JAGITIAL,Karimnagar,Telangana

Ward/Bed No First
Floor,
CICU ,
Bed
no:CICU1
0

Primary Consultant

Dr. KRISHNA CHAITANYA M (

ATYPICAL CHEST PAIN FOR EVALUATION

CAG- NORMAL CORONARIES

LOWER RESPIRATORY TRACT INFECTION
KNOWN CASE OF MYASTHENIA GRAVIS
S/P-THYMECTOMY (2010)
LEFT DIAPHRAGMATIC PALSY

C/o Shortness of breath since 1 day

AT ADMISSION:

Afebrile

PR: 72/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 72 years old female patient Mrs. JEEVITHA known case of myasthenia gravis S/P Thymectomy (2010) with a history of recent LRTI, presented to us with breathlessness. History of left diaphragmatic paralysis post-thymectomy with left lung drawn up. Hence, she has orthopnea and recurrent LRTI's . On evaluation, ECG showed no significant ST -T changes, echo done was normal LV function with antibiotics she was symptomatically better. CAG done was normal coronaries. She was being discharged with following advise.

DISCHARGE MEDICATION:

1. TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.
2. TAB. DISTONIN 60MG THRICE DAILY AT 8AM 2PM 8PM TO CONTINUE.
3. TAB. ABPHYLLINE 100MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. TAXIM-O 200 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
5. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM 2PM 8PM FOR 5 DAYS
6. MDI FORACORT **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
7. CONTINUE C-PAP AT HOME

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2

ARH1.0001234005		Name	Mr. RAJENDRA PRASAD P
Patient Identifier	ARHIP56892	Age	48Yr 0Mth 2Days
Sex	Male	Date of Admission	31-Jul-2022
Date of Discharge			
MLC No			
Address	MANKAMMATHOTA,,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 3
Primary Consultant	Dr Chandra Shekar Sathineni(MD (Internal Medicine))--INTERNAL MEDICINE		

DRUG OVERDOSE

Alleged history of consumed Glimiprime M 0.5 mg, 28 tablets at 11 p.m. on 30/07/2022
Known case of diabetic mellitus

AT ADMISSION:

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 48 years old male patient Mr. RAJENDRA PRASAD P came with c/o alleged history of consumed Glimiprime M 0.5 mg, 28 tablets at 11 p.m. on 30/07/2022, Known case of diabetic mellitus. All necessary investigations were done and diagnosed as DRUG OVERDOSE. Managed conservatively. Psychiatrist consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. PAN-D 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. A TO Z GOLD ONCE DAILY AT 2PM FOR 7 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001233638

Name	Mrs. GAJULA THIRUMALA		
Patient Identifier	ARHIP56757	Age	41Yr 11Mth 28Days
Sex	Female	Date of Admission	23-Jul-2022
Date of Discharge			
MLC No			
Address	7-46/20, GREEN HOMES, CHINTAKUNTA (RURAL), Karimnagar, Telangana	Ward/ Bed No	First Floor, SICU, Bed no: SICU 4
Primary Consultant	DR. SUBRAT KUMAR SOREN		

RTA, SEVERE TRAUMATIC BRAIN INJURY
ACUTE SUBDURAL HAEMATOMA ALONG THE LEFT FRONTO-TEMPORAL REGION WITH MASS EFFECT
DESCENDING TRANSTENTORIAL HERNIATION WITH LONGITUDINAL FRACTURE LEFT TEMPORAL BONE
SURGERY: LEFT DECOMPRESSIVE CRANIECTOMY DONE ON 23/07/22

Alleged history of RTA sustained severe head injury at 8 AM, 23/07/22

History of LOC, since then unresponsive

AT ADMISSION:

Patient was unresponsive, not responding to commands

PR: 55/min

BP: 90/60 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

GCS E1,V2,M4

A 41 years old female patient Mrs. GAJULA THIRUMALA came with alleged history of RTA sustained severe head injury at 8 AM, 23/07/22, history of LOC, since then unresponsive . All necessary investigations were done and diagnosed as RTA, SEVERE TRAUMATIC BRAIN INJURY, ACUTE SUBDURAL HAEMATOMA ALONG THE LEFT FRONTO-TEMPORAL REGION WITH MASS EFFECT, DESCENDING TRANSTENTORIAL HERNIATION WITH LONGITUDINAL FRACTURE LEFT TEMPORAL BONE. SURGERY: LEFT DECOMPRESSIVE CRANIECTOMY DONE ON 23/07/22. Post-operative period was uneventful. Advised to attend Neurorehabilitation centre. Now patient is hemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. FARONEM 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. LEVIPIL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. LASOMIDE 50 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
4. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
5. TAB. REJUNEX CD3 ONCE DAILY AT 8AM FOR 5 DAYS
6. TAB. DOLO 650 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS
7. SYP. DUPHALAC 15 ML 15 ml ONCE DAILY AT 8PM FOR 5 DAYS

REVIEW AFTER 5 DAYS IN NEUROSURGERY OPD

ARH1.0001185397

Patient Identifier

ARHIP56824

Sex

Male

**Date of Discharge
MLC No**

Address

1-
81/2, PUTTAPAKA, MANTHANI, PEDDAPALLI, Karimnagar, Telangana

Primary Consultant

Dr. KRISHNA CHAITANYA M

Name

Mr.
ILLUTAM
RAMULU

Age

62Yr
9Mth
9Days

**Date of
Admission**

27-Jul-
2022

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no: CICU
9

CORONARY ARTERY DISEASE, S/P PCI TO LAD 2017 (2017)
LV DYSFUNCTION,
CKD
HYPERTENSION
DIABETES
BRONCHIAL ASTHMA
CAG: RCA PROXIMAL 80% HAZY STENOSIS
S/P PCI TO RCA (3 X 33 mm XIENCE)
MODERATE LV DYSFUNCTION [EF-40%]

C/o sudden onset severe breathlessness

AT ADMISSION:

Afebrile

PR: 75/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99% on 2 Litr O2

P/A: Soft,

A 62 years old male patient Mr. ILLUTAM RAMULU Known case of CAD, S/P PCI TO LAD 2017 (2017) with risk factors of DM, Hypertension, CKD presented with complaints of sudden onset severe breathlessness. On evaluation, he was diagnosed to be in pulmonary edema. With IV FRUSEMIDE, NIV, he was stabilised and continued on HF regimen. Chest x-ray was suggestive of pulmonary oedema, echo showed severe LV dysfunction and creatinine increased to 2 mg/dL. His diuretics, antidiabetic medication and heart failure regimen were optimized, following which he is stabilised. Once stable, CAG done showed patent stent on left side, but has hazy 80% stenosis in proximal RCA. Once renal parameters improved, PTCA to RCA with 3 x 33 Xience Xpedition stenting done, TIMI III flow. Good result. He was advised low salt diet and strict adherence to medication. He was symptomatically better and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. AZTOR 20MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. FRUSELAC DS ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. ABHYPHYLLINE 200 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. PAN 40MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
8. INJ. WOSULIN 50/50 35 Units AT 8AM, 30/70 25 Units AT 8PM TO CONTINUE.
9. CONTINUE ANTIDIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH CBC, RP2, FBS&PPBS

ARH1.0001233879

Name

Mrs.
VANAMMA
GUDUKADULA

Patient Identifier

ARHIP56858

Age

46Yr
6Mth
4Days

Sex

Female

Date of Admission 28-Jul-2022

Date of Discharge

MLC No

Address

1-101/1,
GODISALA,Karimnagar,Telangana

Ward/Bed No

First
Floor,
MICU,
Bed
no:MIC
U 1

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN
LBBB SR
MILD LV SYSTOLIC DYSFUNCTION (EF-50%)
CORONARY ANGIOGRAM (01/08/22) - NORMAL CORONARIES (LAD MYOCARDIAL BRIDGING)
ADV: MEDICAL MANAGEMENT

C/o chest pain on and off since 1 month

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 98/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 46 years old female patient Mrs. VANAMMA GUDUKADULA came with c/o chest pain on and off since 1 month. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, LBBB SR, MILD LV SYSTOLIC DYSFUNCTION (EF-50%), CORONARY ANGIOGRAM (01/08/22) - NORMAL CORONARIES (LAD MYOCARDIAL BRIDGING), ADV: MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. AZTOR 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PANTOCID 40MG ONCE DAILY AT 7AM BBF FOR 11 DAYS
4. SYP. CREMAFFIN 2 tsp ONCE DAILY AT 8PM

REVIEW AFTER 10 DAYS TO CARDIAC OPD

ARH1.0001120818	Name	Mr. ANGA BHOOMAIA H	
Patient Identifier	ARHIP56868	Age	55Yr 7Mth 4Days
Sex	Male	Date of Admission	29-Jul-2022
Date of Discharge			
MLC No			
Address	GUMLAPUR,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 4
Primary Consultant	Dr. Vidya Sagar A-- CARDIOLOGY		

CORONARY ARTERY DISEASE - UNSTABLE ANGINA

R/F: HTN

CORONARY ANGIOGRAM (01/08/2022) -CAD-LAD mild disease (slow flow present)

PLAN: MEDICAL MANAGEMENT

C/o chest pain and shortness of breath on exertion

Known case of hypertension

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 86/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old male patient Mr. ANGA BHOOMAIAH came with c/o chest pain and shortness of breath on exertion. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE - UNSTABLE ANGINA, CORONARY ANGIOGRAM (01/08/2022) -CAD-LAD mild disease (slow flow present) PLAN: MEDICAL MANAGEMENT . Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 20MG ONCE DAILY AT 8PM TO CONTINUE.
3. TAB. PROLOMET-R 25MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB: DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. RANTAC 150MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001006113		Name	Mr. BALARAJU BACHU
Patient Identifier	ARHIP56818	Age	51Yr 3Mth 6Days
Sex	Male	Date of Admission	26-Jul-2022
Date of Discharge			
MLC No			
Address	8-7-29,NEHRU NAGAR,Karimnagar,Andhra Pradesh	Ward/ Bed No	First Floor, CICU , Bed no:CICU 5
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR
 MODERATE LV SYSTOLIC DYSFUNCTION
 KNOWN CASE OF CAD-AWMI, POST PCI TO LAD (2009)
 CAG[29/07/22]: CAD-DVD [LAD, RCA]
 PTCA TO LAD AND RCA DONE ON 29/07/22
 R/F: HYPERTENSION
 CHECK ANGIO (01/08/22) ; PATENT STENTS IN LAD AND RCA

Complaint of chest pain, SOB since 2 days

AT ADMISSION:

Afebrile

PR: 85/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 51-year-old male patient Mr. BALARAJU BACHU presented with complaint of chest pain. On evaluation diagnosed to have CORONARY ARTERY DISEASE, UNSTABLE ANGINA, SR, MODERATE LV SYSTOLIC DYSFUNCTION, KNOWN CASE OF CAD-AWMI, POST PCI TO LAD (2009), CAG[29/07/22]: CAD-DVD [LAD, RCA], PTCA TO LAD WITH PRONOVA CC 3.5 X 33MM AND RCA PRONOVA CC 3.5 X 28MM DONE ON 29/07/2022. Patient complaints of severe chest pain (burning type) hence check angio done on 01/08/2022 showed patent stents in LAD and RCA. Post operative period was uneventful. Now patient is hemodynamically stable, hence he is being discharged with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. CILODOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. ROZAVEL 40MG ONCE DAILY AT 8PM TO CONTINUE.
5. TAB. PROLOMET-R 25MG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB: DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
7. TAB. VELOZ 20MG ONCE DAILY AT 8AM TO CONTINUE.
8. SYP.GASTRACID 2TSP THRICE IN A DAY AT 8 AM 2 PM 8 PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233877

Name

Mrs.
KOMURAMMA
JANGALLI

Patient Identifier

ARHIP56854

Sex

Female

Date of Discharge
MLC No

Age 66Yr 6Mth
5Days
Date of Admission 28-Jul-2022

Address

6-82, CHAKALI VADA
KOTHAPALLI, Karimnagar, Telangana

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU1
1

Primary Consultant

Dr. KRISHNA CHAITANYA

LRTI

MINOR CAD, SR, MODERATE MR

NORMAL LV FUNCTION
CORONARY ANGIOGRAM (01/08/2022) -Mild CAD

PLAN: MEDICAL MANAGEMENT

C/o chest pain, dyspnea, fever with cough

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 66 years old female patient Mrs. KOMURAMMA JANGALLI presented with c/o chest pain, dyspnea, fever with cough . On evaluation diagnosed to have LRTI, MINOR CAD, SR, MODERATE MR, NORMAL LV FUNCTION, CORONARY ANGIOGRAM (01/08/2022) -Mild CAD, PLAN: MEDICAL MANAGEMENT. Patient treated with antibiotics in view of LRTI. Symptomatically better coronary angiogram done on 01/07/22 showed mild CAD. Plan Medical Management. Patient is asymptomatic and discharged in haemodynamically stable condition with the following advice

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN AV 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. TELMA 20MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. TAXIM-O 200 5MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS
4. SYP. ASCORIL-LS THRICE IN A DAY AT 8 AM 2 PM 8 PM
5. TAB. MONTEK-LC ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. RANTAC 150MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001233989

Name

Mr. CHUKKA
REDDY
KETHIREDDY

Patient Identifier

ARHIP56882

Age

67Yr
7Mth
1Days

Sex

Male

**Date of
Admission**

30-Jul-
2022

Date of Discharge

MLC No

Address

GOWDAPALLY, LUXETTIPET,Telangana

**Ward/Bed
No**

First
Floor,
MICU,
Bed
no:MIC
U 10

Primary Consultant

Dr. RAMCHANDER TORREM(DM(

ACUTE PULMONARY OEDEMA
CKD STAGE V ON MHD

C/o Shortness of breath since 1 day associated with mild cough

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 67 years old male patient Mr. CHUKKA REDDY KETHIREDDY came with c/o Shortness of breath since 1 day associated with mild cough. All necessary investigations were done and diagnosed as ACUTE PULMONARY OEDEMA, CKD STAGE V ON MHD. Managed conservatively. 3 sessions of haemodialysis done. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

ARH1.0001186819

	Name	Mr. ELLAIAH KONDA		
Patient Identifier	ARHIP56845	Age	59Yr 8Mth 11Days	
Sex	Male	Date of Admission	28-Jul-2022	
Date of Discharge MLC No				
Address	GANDHINAGAR, MANDAMARRI,Adilabad(Adilabad),Telangana		Ward/ Bed No	First Floor, MICU, Bed no:MIC U 2
Primary Consultant	Dr. KRISHNA CHAITANYA M (MD)			

LRTI

HYPERTENSION

DIABETES

NORMAL CORONARIES

Complaint of chest pain, breathing difficulty

AT ADMISSION:

Afebrile

PR: 92/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 59 years old male patient Mr. ELLAIAH KONDA known case of hypertension presented with complaint of chest pain, breathing difficulty. On evaluation he was diagnosed as unstable angina with LRTI. His LRTI was managed with IV antibiotics. He's CAG done showed normal coronaries. He was being discharged with following medications.

DISCHARGE MEDICATION:

1. TAB. TAXIM-O 200 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
2. TAB. MONTEK-LC **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
3. TAB. PAN 40 MG **ONCE IN A DAY AT 7 AM BBF** FOR 10 DAYS.
4. TAB. ALLEGRA **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
5. TAB. PULMOCLEAR **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.
6. TAB. GLYCOMET SR 500 MG ONCE DAILY AT 8AM TO CONTINUE.
7. MDI FORACORT **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. SYP. ASCORIL LS 10 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2, FBS & PPBS

ARH1.0001234085	Name	Mr. GANGA MALLAIAH	
Patient Identifier	ARHIP56922	Age	45Yr 0Mth 1Days
Sex	Male	Date of Admission	02-Aug-2022
Date of Discharge			
MLC No			

Address GAMBIRPUR, KATHALAPUR,
JAGITIAL,Karimnagar,Telanga
na

Ward/Bed No First Floor, SICU,
Bed no:SICU 6

Primary Consultant Dr. SURESH GOUD
S(MS,M.Ch
Urology(SVIMS),Consultant
Urologist)--UROLOGY

Consultants

Surgeons Dr. SURESH GOUD
S(MS,M.Ch
Urology(SVIMS),Consultant
Urologist)--UROLOGY

Anesthesiologists Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY

☐ **Diagnosis**
S

Diagnosis

[Add
Diagnosis](#)

ARHIP56922

ARH1.000123408

☐ **Surgery / Procedures
Done**

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
CYSTOSCOPY,URETHRAL DILATATION				

BLADDER OUTFLOW OBSTRUCTION

SURGERY: CYSTOSCOPY+URETHRAL DILATATION DONE ON 02.08.2022

C/o dribbling of urine, urinary retention since 1 day.

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 85/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

All required investigations done and enclosed

A 45 yrs old male patient Mr. GANGA MALLAIAH came to the hospital with c/o dribbling of urine, urinary retention since 1 day. All necessary investigations done and diagnosed as BLADDER OUTFLOW OBSTRUCTION, SURGERY: CYSTOSCOPY+URETHRAL DILATATION DONE ON 02.08.2022. Post operative period was uneventful. Patient symptomatically improved, Patient discharged in haemodynamically stable condition proper medication and advice.

DISCHARGE MEDICATION:

1. TAB: QCEFOR 250 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
2. TAB: DRILGER 250 MG TWICE DAILY AT 8AM, 8PM FOR 5 DAYS.
3. TAB: PAN-D ONCE DAILY AT 7AM BBF FOR 10DAYS.
4. TAB: A TO Z GOLD ONCE DAILY AT 2PM FOR 11DAYS.
5. TAB: VELTAM 0.4 MG ONCE DAILY AT 8PM FOR 11DAYS.
6. SYP. K-CIT 10 ml TWICE DAILY AT 8AM 8PM FOR 10DAYS.

REVIEW AFTER 7 DAYS TO UROLOGY OPD

ARH1.0001233
938

Name

Mr. G
MUTHAIA
H

**Patient
Identifier**

ARHIP56873

Age

70Yr 0Mth 5Days

Sex

Male

**Date of
Admission**

29-Jul-2022

**Date of
Discharge**

MLC No

Address

kachapur,julapelli
mdl,Karimnagar,Telangana
Dr. Venkat Reddy Almareddi
(MS(Orthopaedics),MBA(Healthcar
e),Fellow in Joint

Ward/Bed No

First Floor, SICU,
Bed no:SICU 1

**Primary
Consultant**

Replacement,Fellow in Shoulder
Surgery(USA),Fellow in
Arthroscopy(SIOR),Consultant
Orthopaedic Surgeon)--
ORTHOPAEDICS

Consultants

Surgeons

Dr. KRISHNA CHAITANYA M
(MD,DM,(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY,
Dr. Venkat Reddy Almareddi
(MS(Orthopaedics),MBA(Healthcar
e),Fellow in Joint
Replacement,Fellow in Shoulder
Surgery(USA),Fellow in
Arthroscopy(SIOR),Consultant
Orthopaedic Surgeon)--
ORTHOPAEDICS

**Anesthesiolo
gists**

Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLO
GY

☐ **Diagnosis**

Diagnosis

Disease	Disease Type
	Pd

ARHIP56873	ARH1.000123393
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☐ **Surgery / Procedures
Done**

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
LT CEMENTED BIPOLAR HEMIARTHROPLASTY HIP	30-Jul-2022 15:30:00	30-Jul-2022 17:00:00	Dr. Venkat Reddy Almareddi	Dr Subba Reddy Kuppannagari
CORONARY ANGIOGRAM				

COMMINUTED BASAL IT FRACTURE OF LEFT FEMUR
S/P HEMIARTHROPLASTY OF LEFT HIP WITH CEMENTED BIPOLAR
POST OPERATIVE MI.

C/o pain in left hip are unable to move left leg
History of accidental fall on 28/07/22
Known case of hypertension, diabetes mellitus

Allergic to COMBIFLAM TAB.

AT ADMISSION:

PR: 88/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 63 years old male patient MUTHAIAH came with c/o pain in left hip are unable to move left leg, history of accidental fall on 28/07/22. Known case of hypertension, diabetes mellitus. All necessary investigations were done and diagnosed as COMMUNUTED BASAL IT FRACTURE OF LEFT FEMUR, S/P HEMIARTHROPLASTY OF LEFT HIP WITH CEMENTED BIPOLAR. Patient was intubated and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support. Cardiologist consultation taken and advised CAG. CAG showed LMCA+TVD. Poor prognosis explained to the patient attendants. On 03.08.2022 at 2:10 AM suddenly patient developed severe bradycardia. INJ. Atropine and INJ. ADRENALINE given and patient desaturated. CPR started according to ACLs guidelines. CPR was continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 03.00 AM on 03/02/2022.

CAUSE OF DEATH

CARDIOPULMONARY ARREST SECONDARY TO POST OPERATIVE MI, POST
HEMIARTHROPLASTY.

APH1.0001151100

Name	Mr. KOMARAI AH VANGA		
Patient Identifier	ARHIP56890	Age	59Yr 0Mth 7Days
Sex	Male	Date of Admission	31-Jul-2022
Date of Discharge			
MLC No			
Address	h.no:8-6-403, bhaghat singh nagar, godavarikhani, ramagumdem,, Karimnagar, Telangana		
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		
Ward/ Bed No	First Floor, CICU , Bed no:CICU13		

LEFT LOWER LIMB CELLULITIS
KNOWN CASE OF CAD - ACS - UNSTABLE ANGINA
S/P CAG - TVD (27/07/2012)
S/P CABG - LIMA TO LAD, SVG TO OM/PDA
EFFORT ANGINA (2021)
CAG (2021) NATIVE -TVD PATENT GRAFT
ADVISED: MEDICAL MANAGEMENT
R/F: SMOKING, DM, HYPERTENSION

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 59 years old male patient Mr. KOMARAIHAH VANGA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as LEFT LOWER LIMB CELLULITIS, KNOWN CASE OF CAD - ACS - UNSTABLE ANGINA, S/P CAG - TVD (27/07/2012), S/P CABG - LIMA TO LAD, SVG TO OM/PDA, EFFORT ANGINA (2021), CAG (2021) NATIVE -TVD PATENT GRAFT, ADVISED: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. BETALOC 50MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. RAMISTAR 10MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. MONIT GTN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. FRUSELAC ONCE DAILY AT 8PM TO CONTINUE.
8. TAB. PANTOCID 40MG TWICE DAILY AT 8AM, 8PM FOR 11 DAYS
9. TAB. GLYCOMET SR 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
10. INJ HUMAN MIXTARD 30/70 24 U S/C AT 8AM, 12 U S/C AT 8PM TO CONTINUE.

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

ARH1.0001233546		Name	Mr. KALVA MALLAIAH
Patient Identifier	ARHIP56738	Age	65Yr 0Mth 13Days
Sex	Male	Date of Admission	22-Jul-2022
Date of Discharge			
MLC No			
Address	3-115/8/2, MUQDAMPUR,Karimnagar,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 11
Primary Consultant	Dr Chandra Shekar Sathineni(MD)		

CVA WITH ACUTE INFARCT
UROSEPSIS, METABOLIC ENCEPHALOPATHY

C/o Slurring of speech associated with bilateral lower limbs pain and weakness

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 65 years old male patient Mr. KALVA MALLAIAH came with c/o Slurring of speech associated with bilateral lower limbs pain and weakness. All necessary investigations were done and diagnosed as CVA WITH ACUTE INFARCT, UROSEPSIS, METABOLIC ENCEPHALOPATHY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE IN A DAY AT 2PM TO CONTINUE
2. TAB. STORVAS 40 MG ONCE IN A DAY AT 8PM TO CONTINUE
3. TAB. PAN 40 MG ONCE IN A DAY AT 7 AM BBF FOR 7 DAYS.
4. TAB. URIMAX-D ONCE IN A DAY AT 9 PM FOR 7 DAYS.

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001234096

Name	Mr. P SATHISH KUMAR
Patient Identifier	ARHIP56923
Age	38Yr 0Mth 1Days
Sex	Male
Date of Admission	02-Aug-2022
Date of Discharge	
MLC No	
Address	THILAKNAGAR RAMAGUNDAM,Karimnagar,Telangana
Ward/ Bed No	First Floor, CICU , Bed no:CICU1 1
Primary Consultant	Dr. KRISHNA CHAITANYA M

ECTATIC CORONARIES WITH MINOR CAD

Complaint of severe chest discomfort

AT ADMISSION:

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 38 years old male patient Mr. P SATHISH KUMAR presented with complaint of severe chest discomfort. On evaluation, he was diagnosed as unstable angina. CAG done showed ectatic coronaries with minor CAD. His medications were optimised. He was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN-AV 75/10 MG ONCE IN A DAY AT 8PM TO CONTINUE
2. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
3. TAB. THIAMINE 100 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
4. TAB. NEUROBIAN FORTE ONCE IN A DAY AT 9 PM FOR 7 DAYS.

ADVISED TO STOP ALCOHOL AND TOBACCO

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP2

ARH1.0001021034		Name	Mr. BHOOMESH VALLAKATLA
Patient Identifier	ARHIP56924	Age	55Yr 4Mth 11Day s
Sex	Male	Date of Admission	02- Aug- 2022
Date of Discharge MLC No			
Address	12-37,WARD 24 , SIRICILLA,Karimnagar,Andhra Pradesh	Ward/Bed No	First Floor, Day Care, Bed no:DC 6
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CAD - ATYPICAL CHEST PAIN, SR, MODERATE LV DYSFUNCTION
 KNOWN CASE OF CAD - ACUTE IWSTEMI, TLT WITH STK ON 23/03/12
 CAG 24/03/12 -RECANALISED RCA
 CAG 02/02/22 -CAD-DVD (LAD & RCA)
 PLAN MEDICAL MANAGEMENT (RCA : SLOW FLOW, LAD: MODERATE STENOSIS)
 R/F: HTN, DM

C/o chest pain on and off, SOB since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 97/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 55 years old male patient Mr. BHOMESH VALLAKATLA came with c/o chest pain on and off, SOB since 1 day. All necessary investigations were done and diagnosed as CAD - ATYPICAL CHEST PAIN, SR, MODERATE LV DYSFUNCTION, KNOWN CASE OF CAD - ACUTE IWSTEMI, TLT WITH STK ON 23/03/12, CAG 24/03/12 -RECANALISED RCA, CAG 02/02/22 -CAD-DVD (LAD & RCA), PLAN MEDICAL MANAGEMENT (RCA : SLOW FLOW, LAD: MODERATE STENOSIS). Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 8 TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. TELMA 40MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. FRUSELAC ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MONTAC LC ONCE DAILY AT 2PM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001234063

Name	Mr. KUDIRE SRIKANTH		
Patient Identifier	ARHIP56906	Age	27Yr 0Mth 2Days
Sex	Male	Date of Admission	01-Aug-2022
Date of Discharge			
MLC No			
Address	ramakrishnapur,mandamarri mdl,Mancheria,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 4
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CAD - RWMA, SR, MILD LV SYSTOLIC DYSFUNCTION,
TLT WITH RETEPLASE 10 UNITS AT 12 A.M., 10 UNITS AT 12:30 P.M. ON 01/08/22 (OUTSIDE HOSPITAL)
HYPERLIPIDAEMIA
CAG (03/01/22) : CAD - SVD (LAD)
ADVISE ANTICOAGULATION FOR 6 WEEKS

C/o chest pain, pain radiating to left arm since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 27 years old male patient Mr. KUDIRE SRIKANTH came with c/o chest pain, pain radiating to left arm since 1 day. All necessary investigations were done and diagnosed as CAD - RWMA, SR, MILD LV SYSTOLIC DYSFUNCTION, TLT WITH RETEPLASE 10 UNITS AT 12 A.M., 10 UNITS AT 12:30 P.M. ON 01/08/22 (OUTSIDE HOSPITAL), HYPERLIPIDAEMIA, CAG (03/01/22) : CAD - SVD (LAD), ADVISE ANTICOAGULATION FOR 6 WEEKS. Patient is being discharged in hemodynamically stable condition with required medication and advise. High risk explained to patient attenders and increased risk of bleeding due to anticoagulants.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 75 MG ONCE DAILY AT 8 TO CONTINUE.
2. TAB. CLOPITAB 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. IXAROLA 15 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. STORVAS 80MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. PAN 40MG ONCE DAILY AT 8AM FOR 11 DAYS.
6. TAB. BETALOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001233538

Name

Ms. Y VINEELA

Patient Identifier ARHIP56723

Age 28Yr
0Mth
13Days

Sex Female

Date of Admission 20-Jul-2022

Expired Date 02-Aug-2022
MLC No

Address KORUTLA
JAGITIAL, Karimnagar, Telangana

Ward/Bed No First
Floor,
MICU,
Bed
no: MIC
U 6

Primary Consultant DR. SRI KARAN UDDESH –INTERNAL
MEDICINE

Consultants

Surgeons

Anesthesiologists

☐ **Diagnosis**
S

Diagnosis

Disease	Disease Type
SEPSIS WITH MODS HYPERNATREMIA.	

C/o pedal edema, abdominal distension since 10 days

AT ADMISSION:

Afebrile

PR: 130/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99% on 5 Lit O2

P/A: Soft

A 28 years old female patient ^{VINEELA} presented with the above-mentioned complaints. Patient was started on INJ. MEROPENEM 1 g IV 1-1-1 NORADRENALINE infusion was started as the BP was not recordable, started on oxygen at 8 L/min as patient was not maintaining saturation on room air. An abdominal paracentesis was done and was sent for analysis which showed low sac ascites, gene xpert MTB was negative, it was transudative effusion. Pleural tapping was done about 200 mL and was sent for analysis did not reveal features of TB. The patient improved over the next 48 hours of hospitalisation ionotropic support was stop and oxygen requirement was 2 L/min. On the third day of hospitalisation patient's GCS worsen sudden suddenly she was intubated in view of poor GCS. Neurology consultation was taken a CT brain was done which was normal. Gastroenterology consultation was taken in view of LFT derangement. Neurologist and Gastroenterologist opined that it is probably clinical TB. So patient was started on non-hepatotoxic TB drugs. On the fifth day of hospitalisation with LEVOFLOXACIN ETHAMBUTOL and AMIKACIN. Patient's GCS improved after mechanical ventilation but patient could not be weaned off mechanical ventilation and was requiring inotropic support. Cultures of blood were steriod. Patients LFT continued to Worsen, Gastroenterologist review was taken and Gastroenterologist advised to continue the same. Despite all the above interventions patient clinically deteriorated and had sudden cardiac arrest at 1:20 AM on 02/08/2022, CPR was initiated according to ACLS guidelines despite best efforts patient could not be revived and was declared dead at 1.26 AM on 02/08/2022.

ARH1.0001234014

		Name	Mr. KISTAREDDY K	
Patient Identifier	ARHIP56898	Age	64Yr 0Mth 3Days	
Sex	Male	Date of Admission	31-Jul-2022	
Date of Discharge				
MLC No				
Address	1-70 SRIRAMILAPALLI, Karimnagar, Telangana		Ward/ Bed No	First Floor, CICU , Bed no: CICU 8
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY			

CAD -ACUTE IWMI, CHB
MILD LV DYSFUNCTION
CAG (31/07/22) CAD-SVD (RCA)
TPI DONE ON 31/07/22, PRIMARY PTCA TO RCA WITH PRONOVA CC 3.0 X 33 MM ON 31/07/22
R/F: SMOKING, ALCOHOL,

C/o Left sided chest pain associated with mild sweating since 1 day

AT ADMISSION:

Afebrile

PR: 81/min

BP: 130/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 64 years old male patient Mr. KISTAREDDY came with c/o Left sided chest pain associated with mild sweating since 1 day. All necessary investigations were done and diagnosed as CAD -ACUTE IWMI, CHB MILD LV DYSFUNCTION, CAG (31/07/22) CAD-SVD (RCA), TPI DONE ON 31/07/22, PRIMARY PTCA TO RCA WITH PRONOVA CC 3.0 X 33 MM ON 31/07/22, R/F: SMOKING, ALCOHOL. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPILET 75MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. CILODOC 50 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 4) TAB. TONACT 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 5) TAB. RANTAC 150 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001233670

Name

Mrs. N
MEGHANA

Patient Identifier

ARHIP56916

Age

44Yr
0Mth
11Days

Sex

Female

**Date of
Admission**

02-Aug-
2022

**Date of Discharge
MLC No**

Address

„Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
7

Primary Consultant

Dr. KRISHNA CHAITANYA

CAD, CSA, TMT POSITIVE
CAG -DVD PCI TO LCX AND LAD DONE,
GOOD RESULT
NO HF
SR

History of angina on exertion

AT ADMISSION:

Afebrile

PR: 76/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 44 years old female patient Mrs. N MEGHANA with risk factors of diabetes, hypertension with a history of angina on exertion was evaluated locally. TMT done was stage-II positive. Coronary angiogram done showed double vessel disease. PCI to LAD and LCx done. Good result. TIMI III flow. She had excessive menstrual flow as antiplatelets. Her haemoglobin was monitored on day of discharge Hb 10.5 g/dL. She was asymptomatic. ECG post PCI was normal. She was asymptomatic and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. AXCER 90 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. ECOSPRIN 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. PAN 40MG ONCE DAILY AT 8AM FOR 11 DAYS.
4. TAB. MET-XL 50MG ONCE DAILY AT 2PM TO CONTINUE.
5. TAB. ANXIT 0.25 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. IVABID 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
8. TAB. TELMA -AM 40/5 ONCE DAILY AT 8AM TO CONTINUE.

CONTINUE ANTIDIABETIC MEDICATION AS ADVISED BY PHYSICIAN

REVIEW AFTER 7 DAYS TO CARDIAC OPD WITH CBC, RP2, FBS & PLBS

ARH1.0001234007

Name

Mr. SYED
SAMIUDDI
N

Patient Identifier

ARHIP56893

Age

64Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

31-Jul-
2022

**Date of Discharge
MLC No**

Address

MUKURAMPURA,Karimnagar,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU
1

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

CAD -NSTEMI (TMT POSITIVE)
SR, NORMAL LV SYSTOLIC FUNCTION
KNOWN CASE OF CARCINOMA THYROID
RIGHT HEMITHYROIDECTOMY (2009)
LEFT COMPLETE THYROIDECTOMY (2019)
STABILIZATION OF D8 & D11 MASS EXCISION (2019)
LEFT CATARACT SURGERY MARCH 2022
R/F: HTN, DM
CAG 02/08/22; CAD - TVD (LAD, LCX, RCA)
PLAN CABG

C/o chest pain radiating to both arms, vomiting since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 64 years old male patient Mr. SYED SAMI UDDIN came with c/o chest pain radiating to both arms, vomiting since 1 day. All necessary investigations were done and diagnosed as CAD -NSTEMI (TMT POSITIVE), SR, NORMAL LV SYSTOLIC FUNCTION, KNOWN CASE OF CARCINOMA THYROID, RIGHT HEMITHYROIDECTOMY (2009), LEFT COMPLETE THYROIDECTOMY (2019), STABILIZATION OF D8 & D11 MASS EXCISION (2019), LEFT CATARACT SURGERY MARCH 2022, CAG 02/08/22; CAD - TVD (LAD, LCX, RCA), PLAN CABG. Now patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150 MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPITAB 75 MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. GLYCOMET SR 500MG ONCE DAILY AT 8AM TO CONTINUE.
5. TAB. THYRONORM 150 MCG ONCE DAILY AT 8AM TO CONTINUE.
6. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
7. SYP. POTKLOR 15 ML THRICE DAILY AT 8AM 2PM 8PM FOR 2 DAYS

REVIEW AFTER 7 DAYS IN CARDIAC OPD WITH FBS/PLBS REPORTS

ARH1.0001233602

Name

Mr. CH
VENKATRAJAM

**Patient
Identifier**

ARHIP56813

Age

60Yr 0Mth 12Days

Sex

Male

**Date of
Admission**

26-Jul-2022

**Date of
Discharge**

MLC No

Address

CHANDAPALLI
PEDDAPALLI ,Karimnagar,T
elangana

Ward/Bed No

First Floor, CT
POST, Bed no:CT 4

**Primary
Consultant**

Dr SOMASHEKAR
K(MS,MCH(CTVS),Consultan
t-Cardio Thoracic &
Vascular Surgeon)--C T
SURGERY

Consultants

Surgeons

Dr SOMASHEKAR
K(MS,MCH(CTVS),Consultan
t-Cardio Thoracic &
Vascular Surgeon)--C T
SURGERY

**Anesthesiologi
sts**

Dr. K.S.D.KRISHNA
KIRAN--
ANAESTHESIOLOGY

☐ **Diagnosis**

Diagnosis

[Add
Diagnosis](#)

ARHIP56813

ARH1.0001233602

☐ **Surgery / Procedures
Done**

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
Femoro papliteal art Bypass Grafting RT				

RIGHT PAD OF ATHEROSCLEROTIC ORIGIN WITH GANGRENE OF RIGHT GREAT TOE, 2ND TOE AND 3RD & 4TH TOE WITH LOSS OF 5TH TOES

SURGERY: RIGHT FEMORO PATELART BYPASS GRAFTING DONE WITH 6 mm DACRON GRAFT ON 30/07/2022

C/o Blackish discoloration of big toe, 2nd toe and 3rd, 4th Toe with loss of 5th Toes

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 60 years old male patient VENKATRAJAM presented to hospital with c/o Blackish discoloration of big toe, 2nd toe and 3rd & 4th Toe with loss of 5th Toes . All necessary investigations were done and diagnosed as Right PAD of atherosclerotic origin with gangrene of right great toe, 2nd toe and 3rd, 4th Toe with loss of 5th Toes, Surgery: Right Femoro patelart art Bypass Grafting done on 30/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

BMI is 15.2 kg/m².

Sr. Creatinine report 0.9

PT-INR - 1.4

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ACITROM 1MG ONCE DAILY AT 7PM TO CONTINUE LIFE LONG.
- 3) TAB. ROZAVEL 20MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 5) TAB. FAMOCID 40MG ONCE DAILY AT 7AM (BEFORE FOOD) FOR 5 DAYS.
- 6) TAB. TRAMADOL 50 MG THRICE DAILY AT 8AM 2PM AND 8PM FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD WITH PT/INR

ARH1.0001233302

		Name	Mr. SINGU RAMESH
Patient Identifier	ARHIP56769	Age	49Yr 0Mth 19Days
Sex	Male	Date of Admission	24-Jul-2022
Date of Discharge			
MLC No			
Address	METPALLI JAGITIAL ,Karimnagar,Telangana	Ward/ Bed No	First Floor, CT POST, Bed no:CT 2
Primary Consultant	Dr SOMASHEKAR K(MS,MCH(CTVS),Consultant-Cardio Thoracic & Vascular Surgeon)--C T SURGERY		

CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWMI

SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM]
+IABP DONE ON 29/07/2022.

C/o chest pain a/w SOB since 2 days

ON ADMISSION VITAL

Patient conscious, coherent

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+,

CVS-S1S2+

P/A-Soft,

SPO2-98%

A 49 years old male patient Mr. SINGU RAMESH presented to hospital with c/o chest pain a/w SOB since 2 days . All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE + DOUBLE VESSEL DISEASE + S/P AWMI, SURGERY -CORONARY ARTERY BYPASS GRAFTING [LIMA TO LAD, SVG TO OM] +IABP DONE ON 29/07/2022. Post operative period was uneventful. Now as the patient is hemodynamically stable, hence he is being discharged with required medication and advice.

POST CABG 2D ECHO REPORTS SHOWED, MODERATE LV DYSFUNCTION, MILD MR, TR/PAH , NO PE/CLOT/VEG, EF-35%

BMI is 18.2 kg/m2.

Sr. Creatinine report on 30.07.2022 0.8 mg/dl.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET A (75+150) ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. DYTOR PLUS 5MG ONCE DAILY AT 8AM TO CONTINUE.
- 3) TAB. ND VIT ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. IVERZAC 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 5) TAB. DIXIN 0.25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 6) TAB. ROZAVEL 20 MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) TAB. ROXSAFE CV 500+125 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS.
- 8) TAB. ALPRAX 0.25 MG ONCE DAILY AT 9PM FOR 5 DAYS.
- 9) TAB. TRAMADOL 50MG THRICE DAILY AT 8AM, 2PM AND 8PM FOR 5 DAYS.
- 10) TAB. FAMOCID 40 MG ONCE DAILY AT 7AM BBF FOR 5 DAYS.

REVIEW AFTER 11 DAYS TO CTVS OPD

ARH1.0001234156

Name

Mrs. G SUGUNA

Patient Identifier

ARHIP56954

Age 55Yr 0Mth 0Days

Sex

Female

Date of Admission 04-Aug-2022

Date of Discharge MLC No

Address

LAXMIPUR,Karimnagar,Telangana

Ward/ Bed No Ground Floor, Emergency Ward, Bed no:EME2

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

ATYPICAL CHEST PAIN, SR
NORMAL LV SYSTOLIC FUNCTION EF 60%
CAG (08/04/2022) - NORMAL CORONARIES
ADV: MEDICAL MANAGEMENT

C/o chest pain on and off since 5 days

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 55 years old female patient ^{SUGUNA} came with c/o chest pain on and off since 5 days. All necessary investigations were done and diagnosed as ATYPICAL CHEST PAIN, SR, NORMAL LV SYSTOLIC FUNCTION EF- 60%, CAG (08/04/2022) - NORMAL CORONARIES, ADV: MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM AFTER LUNCH TO CONTINUE.
2. TAB. NEXPRO 40MG ONCE DAILY AT 8AM BEFORE BREAKFAST TO CONTINUE.
3. TAB. TONACT 10MG ONCE DAILY AT 8PM AFTER DINNER TO CONTINUE.
4. TAB. MYOSPAS **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS

REVIEW AFTER 7 DAYS TO CARDIAC OPD

ARH1.0001233948		Name	Mrs. BHADRAVVA CHINDHAM
Patient Identifier	ARHIP56875	Age	70Yr 0Mth 6Days
Sex	Female	Date of Admission	29-Jul-2022
Date of Discharge			
MLC No			
Address	H.NO:2-46,GHARSHAKURTHI.GANGADHARA,KARIMNAGAR,Telangana	Ward/Bed No	First Floor, MICU, Bed no:MICU 9
Primary Consultant	DR. NIKHIL GOLI		

ACUTE INFARCTS IN POSTERIOR CIRCULATION

C/o slurring of speech, altered sensorium since 2 days
H/o fever and vomitings 3 episodes

Known case of hypertension on regular medication

AT ADMISSION:

Patient c/c

PR: 79/min

BP: 130/80 mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 70 years old female patient Mrs. BHADRAVVA CHINDHAM came with c/o slurring of speech, altered sensorium since 2 days, h/o fever and vomitings 3 episodes. All necessary investigations were done and diagnosed as ACUTE INFARCTS IN POSTERIOR CIRCULATION. Patient attendants requested for discharge, hence patient is getting discharged at request.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. MODALERT 100 MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. STROCIT 500 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE
- 5) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 7 DAYS

REVIEW AFTER 7 DAYS TO DR. NIKHIL GOLI sir OPD

56676

ARH1.0001231631

Name	Mr. MOHAMMED ABDUL HAMEED
Patient Identifier	ARHIP56676
Age	54Yr 2Mth 3Days
Sex	Male
Date of Admission	18-Jul- 2022
Date of Discharge	19-Jul-2022
MLC No	
Address	janagam,,Jangaon,Telangana
Ward/Bed No	First Floor, SICU, Bed no:SICU

Primary Consultant Surgeons DR. SUBRAT KUMAR SOREN --
NEUROSURGERY

Consultants
Anesthesiologists

Diagnosis
S

Diagnosis

Disease	Disease Type
TRAUMATIC BRAIN INJURY,SAH	

Alleged h/o RTA, skid and fall from bike on 18/07/2022 at 1 PM sustained injury to head

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 80/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

GCS-E4,V1,M6

A 54 years old male patient Mr. MOHAMMED ABDUL HAMEED came with alleged h/o RTA, skid and fall from bike on 18/07/2022 at 1 PM sustained injury to head. All necessary investigations were done and diagnosed as TRAUMATIC BRAIN INJURY,SAH. Managed conservatively. Patient condition and need for further

hospitalization explained to patient attendants but they want to leave against medical advice, so patient being discharged under LAMA

ARH1.0001234080

Name

Mr. RAPELLY
NARAYANA

**Patient
Identifier**

ARHIP56917

Age

65Yr
0Mth
3Days

Sex

Male

**Date of
Admission**

02-Aug-
2022

**Date of
Discharge
MLC No**

Address

21-05-38(C-16), GOUTHAMINAGAR,
GODAVARIKANI, PEDDAPALLI, Karimnagar, Telang
ana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no: MIC
U 3

**Primary
Consultant**

Dr Chandra Shekar Sathineni(MD (Internal
Medicine))--INTERNAL MEDICINE

ACUTE FEBRILE ILLNESS

UROSEPSIS

PARKINSON'S DISEASE

AKI

C/o fever since 2 days, decreased response since 1 day
K/c/o Akinetic rigid syndrome
Parkinson's disease on regular medication

AT ADMISSION:

Afebrile

PR: 90/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 65 years old male patient Mr. RAPELly NARAYANA came with c/o fever since 2 days, decreased response since 1 day. K/c/o Akinetic rigid syndrome, parkinson's disease on regular medication. All necessary investigations were done and diagnosed as ACUTE FEBRILE ILLNESS, UROSEPSIS, PARKINSON'S DISEASE, AKI. Managed conservatively. Psychiatric consultation taken and advice followed. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. SYNDOPA PLUS THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS
- 2) TAB. PANTOCID -L ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 3) TAB. UB GOLD ONCE DAILY AT 2PM FOR 15 DAYS
- 4) TAB. PRAMIPEX 1 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 5) TAB. QUITIPIN 50 MG AT 8AM AND 25 MG AT 8PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001234058

Name

Mrs. LAXMI
CHEEKATLA

**Patient
Identifier** ARHIP56925

Age 48Yr 7Mth
4Days

Sex Female

**Date of
Admission** 02-Aug-
2022

**Date of
Discharge**
MLC No

Address 3-77,SWAPNA
COLONY,SULTHANABAD,PEDDAPALLI,Karimnagar,Telang
ana

**Ward/
Bed No** First Floor,
RECOVERY
ROOM, Bed
no:RR 8

**Primary
Consultant** Dr. GOUTHAM ROY (

GALLSTONE DISEASE

SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 04.08.2022

C/o abdominal pain, vomiting, motions since 1 month
K/c/o HTN

PHYSICAL EXAMINATION:

ON ADMISSION

Afebrile

PR-82/min

BP-120/80mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 48 yr old female patient Mrs. LAXMI CHEEKATLA came with c/o abdominal pain, vomiting, motions since 1 month. All necessary investigations done and diagnosed as GALLSTONE DISEASE, SURGERY: LAPROSCOPIC CHOLECYSTECTOMY DONE ON 04.08.2022. Findings: Well distended gallbladder with well defined calot's. Post operative period was uneventful. Now as the patient is haemodynamically stable, hence he is being discharged with required medication and advice.

DISCHARGE MEDICATION:

1. TAB: ROXSAFE 500MG TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: ND PAIN TWICE DAILY AT 8AM, 8PM FOR 5 DAYS
3. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS
5. GLUTAVAUULT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.

Review after 7 days in General Surgery OPD.

ARH1.0001234108

Name

Mrs.
VEERALAXMI
MANCHALA

Patient Identifier

ARHIP56935

Age

38Yr
9Mth
5Days

Sex

Female

**Date of
Admission**

03-Aug-
2022

Date of Discharge

MLC No

Address

BOYAWADA,Karimnagar,Telangana

**Ward/Bed
No**

First
Floor,
MICU,
Bed
no:MIC
U 1

Primary Consultant

Dr Chandra Shekar Sathineni

SEPSIS
? GLYCOGEN STORAGE DISORDER
ANAEMIA

C/o sudden fall at bathroom associated with profuse sweating and giddiness, initially treated at outside hospital and came here for further management

AT ADMISSION:

Afebrile

PR: 80/min

BP: 100/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 38 years old female patient Mrs. VEERALAXMI MANCHALA came with c/o sudden fall at bathroom associated with profuse sweating and giddiness, initially treated at outside hospital and came here for further management. All necessary investigations were done and diagnosed as SEPSIS, ? GLYCOGEN STORAGE DISORDER, ANAEMIA. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

- 1) TAB. TAXIM-O 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 2) TAB. CALPOL 500 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
- 3) TAB. PAN-D 40 MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
- 4) TAB. A TO Z ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 5 DAYS IN GENERAL MEDICINE OPD

ARH1.0001234106		Name	Mr. HANUMANTH U JALAPATHI
Patient Identifier	ARHIP56934	Age	40Yr 0Mth 0Days
Sex	Male	Date of Admission	03-Aug- 2022
Date of Discharge			
MLC No			
Address	3-21 THANGALAPLLIE,Karimnagar,Telangana	Ward/Bed No	First Floor, CICU , Bed no:CICU1 0
Primary Consultant	Dr. KRISHNA CHAITANYA M		

LRTI

MINOR CAD

TOBACCO

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 80/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 40 years old male patient Mr. HANUMANTHU JALAPATHI presented with history of chest pain, fever cough. On evaluation, his ECG done showed T inversion in II, III, aVF suggestive inferior wall changes. CAG done showed minor CAD, IV antibiotics and other supportive medication continued. He improved with medication and symptomatically better and haemodynamically stable at discharge.

DISCHARGE MEDICATION:

1. TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS
2. SYP. ASCORIL LS **THRICE IN A DAY AT 8 AM 2PM 8 PM** FOR 7 DAYS
3. TAB. ACEBROPHYLLINE + N-ACETYLCYSTEINE **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
4. TAB. MONTEK LC **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. ECOSPRIN -AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.
6. TAB. TAXIM-O 200 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 5 DAYS.

REVIEW AFTER 7 DAYS TO CARDIAC OPD CBC, RP2

56889 radha 70

CORONARY ARTERY DISEASE, AWM, SR

MILD LV DYSFUNCTION, EF-43%

CORONARY ANGIOGRAM DONE ON 02/08/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.5 X 12 MM PRONOVA DONE ON 02/08/2022
SEIZURES

C/o chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 82/min

BP: 120/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 70 years old female patient Mrs. RADHA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CORONARY ARTERY DISEASE, AWM, SR, MILD LV DYSFUNCTION, EF-43%, CORONARY ANGIOGRAM DONE ON 02/08/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.5 X 12 MM PRONOVA DONE ON 02/08/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. CLOPITAB 75 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
- 4) TAB. EPILIVE 500 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. PAN 40 MG ONCE DAILY AT 8AM FOR 10 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

ARH1.0001222498

Name

Mr. B
NAMPALLY

Patient
Identifier

ARHIP56905

Sex

Male

Expired
Date

04-Aug-2022

MLC No

Address

JAGITYAL,Karimnagar,Telangana

Primary
Consultant

Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General
Surgeon)--GENERAL SURGERY

Surgeons

Dr. GOUTHAM ROY (MS(General
Surgery),Consultant General
Surgeon)--GENERAL SURGERY

Age

74Yr 9Mth 27Days

Date of
Admission

01-Aug-2022

Ward/Bed No

First Floor, SICU,
Bed no:SICU 6

Consultants

Anesthesiologists

Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY

Cause of
Death

Cause of Death

A dropdown menu for Cause of Death. The top part is a white box with a small downward arrow on the right. Below it is a row of three colored boxes: a light blue box with a left arrow, a dark grey box, and a light blue box with a right arrow.

Diagnosis

Diagnosis

Disease	Disease Type
INTESTINAL OBSTRUCTION RADIATION RESECTION.	Pd

C/o pain abdomen since 1 month
K/c/o Ca Rectum

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c

afebrile

PR-68/min

BP-110/70mmhg

RR-18/min

RS-BAE+

CVS-S1S2+

SPO2-98%

A 75 yrs old male patient came Mr. NAMPALLY came with c/o pain abdomen since 1 month, K/c/o Ca Rectum. All necessary investigations done and diagnosed as INTESINAL OBSTRUCTION, REDIATION RESECTION , SURGERY: EXPLORATORY LAPAROTOMY + JEJUNO-ILEAL RESECTION AND ANASTOMOSIS DONE ON 02/08/2022. Patient was on ventilator. On 04/08/22 patient had sudden cardiac arrest. CPR started according to ACLS guidelines Inj. Adrenaline given every 3 minutes. Patient not responded to given treatment. CPR continued. Multiple doses of inj. Adrenaline given. Patient not reverted to Normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 12.56 PM on 04/08/2022.

CAUSE OF DEATH

CARDIORESPIRATORY ARREST SECONDARY TO CANCER CACHEXIA

ARH1.0001015086

		Name	Mr. MALLESHAM N	
Patient Identifier	ARHIP56929	Age	62Yr 9Mth 0Days	
Sex	Male	Date of Admission	02-Aug-2022	
Date of Discharge				
MLC No				
Address	3-50 THEGALAGUTTAPALLY KARIMNAGAR, Karimnagar, Andhra Pradesh		Ward/ Bed No	First Floor, CICU , Bed no: CICU 9
Primary Consultant	Dr. KRISHNA CHAITANYA M			

CAD , S/P PTCA , NOW REST ANGINA , NO HF , SR ,
TRIPLE VESSEL DISEASE, PLAN : CABG.

Complaints of chest pain at rest

AT ADMISSION:

Afebrile

PR: 70/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 62 yrs old male patient Mr. MALLESHAM, known case of CAD, S/P PTCA, presneted with complaints of chest pain at rest . He was admitted in CICU and managed medically. Coronary angiogram done showed Triple vessel disease. He was advised early revascularisation, CABG . He is Hemodynamically stable but needs early revascularisation .

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN 150MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ATORVA 40MG ONCE DAILY AT 8PM TO CONTINUE.
4. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
6. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
7. TAB. MET XL 12.5 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS TO CARDIAC OPD WITH CBC, RP2 & ECG

ARH1.0001232189

Name

Mr. G
ANJANEYULU

Patient Identifier

ARHIP56969

Age

29Yr
1Mth
20Days

Sex

Male

Date of Admission

05-
Aug-
2022

**Date of Discharge
MLC No**

Address

ARADAPALLI ,Karimnagar,Telangana

**Ward/Bed
No**

First
Floor,
Day
Care,
Bed
no:DC
1

Primary Consultant

Dr. KRISHNA CHAITANYA

CHEST PAIN, NORMAL LV FUNCTION, NO HF, SR
MID LAD MYOCARDIAL BRIDGING

Complaint of chest pain

AT ADMISSION:

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 29 yrs old male patient ^{Mr. ANJANEYULU} presented with complaints of chest pain. Coronary angiogram done showed myocardial bridging, Medication optimized. He is asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

1. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
2. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
3. TAB. MET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
5. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 1 MONTH IN CARDIAC OPD WITH CBC, RP2

56968

CRHD, S/P MVR (1993)
NORMAL PV FUNCTION
NORMAL LV FUNCTION
NO HF
SR
TRANSIENT ISCHAEMIC ATTACK

Complaint of weakness of left upper limb and slurring of speech.

AT ADMISSION:

Afebrile

PR: 100/min

BP: 110/80mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 59 years old male patient Mr. NAGESWAR RAO, known case of MVR (1993) presented with complaint of weakness of left upper limb and slurring of speech. On evaluation, Normal prosthetic valve function. ECG showed atrial fibrillation with controlled ventricular rate. His INR done was 1.8. His Acitrom dose was adjusted and advise 2 mg and repeat INR on 08/08/2022. Shall review in OPD with INR report.

DISCHARGE MEDICATION:

1. TAB. ACITROM 2 MG ONCE DAILY AT 7PM TO CONTINUE.
2. TAB. PROLOMET-XL 50 MG ONCE DAILY AT 8AM TO CONTINUE.
3. TAB. DYTOR PLUS 10 MG ONCE DAILY AT 8AM TO CONTINUE.
4. TAB. TONACT ASP 75/10 ONCE DAILY AT 8PM TO CONTINUE.

REVIEW ON 08/08/2022 IN CARDIAC OPD WITH CBC, RP2 & INR REPORT

ARH1.0001234072

Name

Mrs. K
RAJAVVA

Patient Identifier

ARHIP56914

Age

40Yr
0Mth
3Days

Sex

Female

**Date of
Admission**

02-Aug-
2022

**Date of Discharge
MLC No**

Address

GUNJAPADUGU,
GOLLAPALLY,
JAGITYAL,Telangana

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 6

Primary Consultant

Dr Chandra Shekar Sathineni

ADHF
LRTI

Complaints of fever since 20 days,
Cough since 5 days,
Pedal oedema since 10 days
Shortness of breath since 1 day

History of CAD 20 years ago

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 81/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 40 years old female patient Mrs. K. RAJAVVA came with c/o fever since 20 days, cough since 5 days, Pedal oedema since 10 days, shortness of breath since 1 day. All necessary investigations were done and diagnosed as ADHF, LRTI. Pulmonologist consultation taken and advice followed. Patient attendants requested for discharge, hence patient is being discharged at request.

DISCHARGE MEDICATION:

1. TAB. FPM ACT 200 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
2. TAB. PULMOCLEAR TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS
3. TAB. PAN 40 MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.
4. TAB. BILAHENZ-M ONCE DAILY AT 8PM FOR 5 DAYS
5. TAB. PROLOMET XL 50 MG ONCE DAILY AT 8PM FOR 10 DAYS
6. TAB. DYTOR PLUS 20 MG ONCE DAILY AT 8AM FOR 10 DAYS
7. TAB. LINOZID 600 MG TWICE DAILY AT 8AM AND 8PM FOR 5 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

ARH1.0001234128

Name

Mr. CH RAMA RAO

Patient Identifier ARHIP56944

Sex Male

Date of Discharge

MLC No

Address utnoor,Adilabad(Adilabad),Telangana

Primary Consultant Dr. KRISHNA CHAITANYA M

Age
Date of Admission

40Y

03-A

Ward/Bed No

First

CAD - UA, SR, NORMAL LV SYSTOLIC FUNCTION
CAG (05/08/22); NORMAL CORONARIES
PLAN; MEDICAL MANAGEMENT

Complaint of chest pain

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 40-year-old male patient named RAMA RAO presented with complaint of chest pain. On examination diagnosed as CAD - UA, SR, Normal LV systolic function, Coronary angiogram done on 05/08/22: Normal Coronaries, Advised: Medical management. He is asymptomatic and stable at discharge.

DISCHARGE MEDICATION:

1.TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE

Review after 11 days with CBC, RP2

ARH1.0001161054

Name	Mr. SONNAILA LINGAIAH		
Patient Identifier	ARHIP56959	Age	50Yr 11Mth 29Days
Sex	Male	Date of Admission	04-Aug-2022
Date of Discharge			
MLC No			
Address	17-3-470,INDRA NAGAR,PEDDAPALLI DISTRICT,Karimnagar,Telangana	Ward/ Bed No	First Floor, MICU, Bed no:MICU 4
Primary Consultant	Dr. KRISHNA CHAITANYA		

CAD - UA, (TMT POSITIVE)
CAG (05/08/22); NORMAL CORONARIES
PLAN: MEDICAL MANAGEMENT

Complaint of chest pain, palpitations

AT ADMISSION:

Afebrile

PR: 48/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 50-year-old male patient named Mr. SONNAILA LINGAIAH presented with complaint of chest pain. On evaluation TMT found to be positive, diagnosed as CAD - UA. Coronary angiogram done on 05/08/22 showed normal coronaries. Advised: Medical management. Patient is asymptomatic and discharged in haemodynamically stable condition with following advice

DISCHARGE MEDICATION:

1.TAB. ECOSPRIN AV 75/10 MG ONCE DAILY AT 8PM TO CONTINUE.

2.TAB. COBADEX ONCE DAILY AT 2PM TO CONTINUE.

3. TAB. PAN 40 MG ONCE DAILY AT 7AM (BBF) FOR 10 DAYS.

4.TAB. PCM 500 MG SOS

Review after 11 days with CBC, RP2

ARH1.0001036572

Name

Mr. M MALLA
REDDY

Patient Identifier

ARHIP56941

Age

64Yr
5Mth
10Days

Sex

Male

**Date of
Admission**

03-Aug-
2022

**Date of Discharge
MLC No**

06-Aug-2022

Address

THEEGALAGUTTA
PALLY,,Karimnagar,Andhra Pradesh

Ward/Bed No

First
Floor,
CICU ,
Bed
no:CICU
5

Primary Consultant

Dr. KRISHNA CHAITANYA M (MD,DM,
(FNB) INTERVENTIONAL
CARDIOLOGIST)--CARDIOLOGY

Consultants

Surgeons

**Anesthesiologi
sts**

Diagnosis
S

Diagnosis

Disease	Disease Type
CAD,old AWMI, PTCA to LAD(BMS)2004 VT(2020)Reverted with DC Cardioversion CAG(2020)LAD80%ISR, RCA proximal 80% LAD 30% viability, PTCA to RCA(2020) SEVERE LV DYSFUNCTION, HF, SR, NOW:SEVERE ANEMIA secondary to GASTROINTESTINAL BLEED. BLOOD TRANSFUSION DONE PLAN: UGISCOPY + COLONOSCOPY	

`C/o dyspnea, palpitations, fatigue

AT ADMISSION:

Afebrile

PR: 60/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 99%

P/A: Soft

A 64 yrs old male Mr. M MALLA REDDY known case of CAD, S/P PCI (2004, 2020) severe LV dysfunction, controlled HF, presented with symptoms of dyspnea, palpitations, fatigue. He was evaluated and diagnosed to have severe anaemia. (Hb - 5.8 gm/dL). He was referred for blood transfusion and management of heart failure. He was transfused 2 packed red cells under cover of I.V diuretics. His haemoglobin improved to > 9 gm/dL. He was advised UGI scopy and colonoscopy for evaluation of GI bleed. He was symptomatically better and haemodynamically stable. He was strongly advised against excessive Ethanol intake.

DISCHARGE MEDICATION:

- 1) TAB. CLOPILET 75 MG ONCE DAILY AT 2PM TO CONTINUE.
- 2) TAB. ATORVA 40 MG ONCE DAILY AT 8PM TO CONTINUE.
- 3) TAB. ALDACTONE 25 MG ONCE DAILY AT 8AM TO CONTINUE.
- 4) TAB. CORDARONE 200 MG ONCE DAILY AT 8AM TO CONTINUE.
- 5) TAB. IVABID 5 MG TWICE DAILY AT 8AM AND 8PM TO CONTINUE.
- 6) TAB. LASIX 40 MG 1 TAB AT 8AM, ½ TAB AT 2PM & 1 TAB AT 8PM TO CONTINUE.
- 7) TAB. PANTODAC 40 MG TWICE DAILY AT 8AM AND 8PM FOR 10 DAYS.
- 8) TAB. SORBITRATE 5 MG S/L SOS
- 9) SYP. SUCRAL-O 2 tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM
- 10) SYP. LACTIFIBER 3 tsp ONCE IN A DAY AT 8 PM

LOW SALT DIET

NO ETHANOL

NO PICKLES

REVIEW AFTER 11 DAYS WITH CBC, RP2

ARH1.0001038994

Name

Mr. G
ARJUN

Patient Identifier

ARHIP56960

Age

50Yr
3Mth
28Days

Sex

Male

Date of Admission

04-Aug-2022

Date of Discharge
MLC No

Address

SIRCILLA,Karimnagar,Andhra Pradesh

Ward/Bed No

First Floor,
CICU ,
Bed no:CICU 7

Primary Consultant

Dr. KRISHNA CHAITANYA M (

CAD - NSTEMI, SR NORMAL LV FUNCTION
CAG (04/08/22): TVD (LAD, LCX, RCA)
PLAN CABG

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 50-year-old male patient named ARJUN presented with complaint of chest pain. On evaluation diagnosed to have CAD - NSTEMI (TROP-T Positive) SR, normal LV function. Coronary angiogram done on 04/08/22 showed TVD (LAD, LCX, RCA) Advised: CABG. Patient attenders explained the need for revascularisation. Patient is discharged in haemodynamically stable condition.

DISCHARGE MEDICATION:

1. TAB. AZTOR 40 MG ONCE DAILY AT 8PM TO CONTINUE.

2. TAB. PANTODAC 40 MG ONCE DAILY AT 8AM FOR 10 DAYS.
3. TAB. NIKORAN 5 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
4. TAB. NITROCONTIN 2.6 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
5. TAB. MET XL 25 MG ONCE DAILY AT 8AM TO CONTINUE.

REVIEW AFTER 11 DAYS IN CARDIAC OPD WITH CBC, RP2

ARH1.0001177681

Name

Mr. T
SATHISH

Patient Identifier

ARHIP56828

Age

40Yr 1Mth
11Days

Sex

Male

Date of Admission

27-Jul-
2022

Date of Discharge
MLC No

27-Jul-2022

Address

P H COLONY,.\D-
1787,GODAVARIKHANI,Karimnagar,Telang
ana

Ward/Bed No

Ground
Floor,
Emergenc
y Ward,
Bed
no:EME5

Primary Consultant

Dr. RAMCHANDER
TORREM(DM(NEPHROLOGY)(NIMS),RENAL
TRANSPLANT PHYSICIAN)--NEPHROLOGY

Consultants

Surgeons

Anesthesiologists

☐ **Diagnosis**
S

Diagnosis

Disease	Disease Type
CHRONIC KIDNEY DISEASE.	

C/o Severe shortness of breath, melaena and hypoglycaemic status
Known case of CKD on MHD

AT ADMISSION:

Patient unconscious status
PR: 65/min

BP: not recordable

CVS: S1S2

RR: 18/min

SPO2: 90%

P/A: Soft,

A 40 years old male patient SATHISH presented to ER with c/o Severe shortness of breath, melaena and hypoglycaemic status. Known case of CKD on MHD. All necessary investigations were done and diagnosed as CHRONIC KIDNEY DISEASE . Patient was intubated in view low saturation. Patient suddenly developed VT, 200 joules shock given which CPR was started according to ACLS guidelines INJ. ATROPINE and INJ. ADRENALINE given and CPR continued, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 2.09 PM on 27/07/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO CKD

ARH1.0001233876

Name	Mrs. RAJESHWARI MANDALA
Patient Identifier	ARHIP56857
Age	59Yr 6Mth 2Days
Sex	Female
Date of Admission	28-Jul-2022
Expired Date	30-Jul-2022
MLC No	
Address	5-3-249,AHMEDPURA,Karimnagar,Telangana
Ward/Bed No	First Floor, SICU, Bed no:SICU 5
Primary Consultant	Dr. Iftekarali (MS (Orthopaedics),Consultant Orthopaedic Surgeon)--ORTHOPAEDICS
Consultants	
Surgeons	
Anesthesiologists	

Diagnosis

Diagnosis

Disease	Disease Type
.	

COR-PULMONALE SEVERE PAH,
SEVERE-TR WITH
INTERTROCHANTERIC FRACTURE

Alleged history of slip and fall at home injury to right hip
Known case of hypertension, diabetic mellitus, severe TR and PAH

AT ADMISSION:

Afebrile

PR: 94/min

BP: 90/60mmHg

RS: BAE+

CVS: S1S2

RR: 16/min

SPO2: 98%

P/A: Soft,

A 59 years old female patient Mrs. RAJESHWARI MANDALA presented to ER with alleged history of slip and fall at home injury to right hip. Known case of hypertension, diabetic mellitus, severe TR and PAH. All necessary investigations were done and diagnosed as COR-PULMONALE SEVERE PAH, SEVERE-TR WITH, INTERTROCHANTERIC FRACTURE. Patient was intubated in view low saturation. Patient sudden cardiac arrest. CPR was started according to ACLS guidelines INJ. ATROPINE and INJ. ADRENALINE given and CPR continued for 4 cycles, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 5.22 PM on 30/07/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO COR-PULMONALE SEVERE PAH, SEVERE-TR
WITH
INTERTROCHANTERIC FRACTURE

56836

A 48 years old male patient Mr. MD. ALI presented to hospital with C/o shortness of breath grade-3 since 3days associated with mild cough and epigastric pain All necessary investigations were done and diagnosed as ACUTE KIDNEY INJURY. Patient was intubated in view low saturation. Patient sudden cardiac arrest. CPR was started according to ACLS guidelines INJ. ATROPINE and INJ. ADRENALINE given and CPR continued for 3 cycles, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 6.24 AM on 01/08/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO ACUTE KIDNEY INJURY

ARH1.0001093335

		Name	Mrs. ASIFA FATHIMA	
Patient Identifier	ARHIP56988	Age	46Yr 9Mth 4Days	
Sex	Female	Date of Admission	06-Aug-2022	
Date of Discharge				
MLC No				
Address	KHARKHANA GADDA,Karimnagar,Telangana		Ward/ Bed No	First Floor, RECOVERY ROOM, Bed no:RR 2
Primary Consultant	Dr. KRISHNA CHAITANYA M			

CAD-NSTEMI

Complaint of chest pain, peripheral neuropathy

AT ADMISSION:

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 46 years old female patient Mrs. ASIFA FATHIMA presented with Complaint of chest pain, peripheral neuropathy. On evaluation, he was diagnosed as unstable angina. CAG done showed no significant obstructive CAD. Her medications were optimised. She is being discharge with following medication.

DISCHARGE MEDICATION:

-
1. TAB. ECOSPRIN-AV 75/10 MG ONCE IN A DAY AT 8PM TO CONTINUE
 2. TAB. OROFLEX XT ONCE IN A DAY AT 2 PM FOR 7 DAYS.
 3. TAB. ANXIT 0.25 MG ONCE IN A DAY AT 8 PM FOR 7 DAYS.
 4. CONTINUE DIABETIC MEDICATION

REVIEW AFTER 3 MONTHS / SOS

ARH1.0001234155

Name

Ms. KOUSALYA
BURLA

Patient Identifier ARHIP56953

Age 68Yr
0Mth
5Days

Sex Female

Date of Admission 04-
Aug-
2022

Expired Date 08-Aug-2022
MLC No

Address Other

Ward/Bed No Second
Floor,
Female
General
I Ward,
Bed
no:GW
3

Primary Consultant Dr. Vidya Sagar A--CARDIOLOGY

Consultants

Surgeons Dr. Vidya Sagar A--CARDIOLOGY

Anesthesiologists

Diagnosis
S

Diagnosis

Disease	Disease Type
CAD-IWMI,SR,MILD LV DYSFUNCTION,S/P TLT WITH ELAXIM ON (02/08/2022),HTN,DM	

C/o chest pain since 1 day

AT ADMISSION:

PR: 82/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 98%

P/A: Soft

A 68 years old female patient Ms. KOUSALYA BURLA came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as CAD-IWMI,SR,MILD LV DYSFUNCTION,S/P TLT WITH ELAXIM ON (02/08/2022),HTN,DM. Poor prognosis explained to the patient attendants. On 06.08.2022 at 4.00 PM patient got cardiac arrest. INJ. Atropine and INJ. ADRENALINE given and patient desaturated, immediately, emergency intubation was done and connected to mechanical ventilator on SIMV mode with Fio2-100% and ionotropic support was given. CPR started immediately, continued for 45 minutes, according to ACLs guidelines. CPR was given and continued but patient not reverted. 12 lead ECG showed flat line, peripheral pulses not felt, declared death at 04.54 PM on 06/08/2022.

CAUSE OF DEATH

SUDDEN CARDIORESPIRATORY ARREST SECONDARY TO CAD-IWMI,SR,MILD LV DYSFUNCTION,S/P TLT WITH ELAXIM ON (02/08/2022),HTN,DM

ARH1.0001222831

Name

Mr. RAMAGIRI
BAPU

**Patient
Identifier**

ARHIP56995

Age

45Yr
11Mth
22Days

Sex

Male

**Date of
Admission**

07-Aug-
2022

**Date of
Discharge
MLC No**

Address

SUDDAL KARIMNAGAR ,Telangana

**Ward/
Bed No**

First
Floor,
CICU ,
Bed
no:CICU7

**Primary
Consultant**

Dr. KRISHNA CHAITANYA M (

MINOR CAD, NORMAL LV FUNCTION, SR

CKD

Complaint of chest pain

AT ADMISSION:

Afebrile

PR: 90/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 45 years old male patient Mr. RAMAGIRI BAPU presented with complaint of chest pain. On evaluation, he was diagnosed as CAD-EVOLVED IWMI (TROP-T POSITIVE), SR WITH NORMAL LV FUNCTION. CAG done on 08/08/2022 showed mild CAD. Advised medical management. Nephrologist consultation done in view of high creatinine, known case of CKD and treated accordingly. Patient is asymptomatic and discharged in haemodynamically stable condition .

DISCHARGE MEDICATION:

1. TAB. ECOSPRIN-AV 75/10 MG ONCE IN A DAY AT 8PM TO CONTINUE
2. TAB. FLAVEDAN MR 35 MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
3. TAB. KETOCHECK **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
4. TAB. RENOSAVE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE
5. TAB. SOBINIX 500 MG ONCE IN A DAY AT 2 PM TO CONTINUE
6. TAB. CUDCE **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.

REVIEW AFTER 1 WEEK WITH CBC, RP2, FBS & PLBS REPORTS AT CARDIAC AND NEPHROLOGY OPD

ARH1.0001233533

Name Mr. MALLAIAH
KYATHAM

Patient Identifier ARHIP56951

Age 73Yr 0Mth 20Days

Sex Male

Date of Admission 04-Aug-2022

Date of Discharge

MLC No

Address POSANIPET, KATHALAPUR,
JAGITIAL,Karimnagar,Telanga
na

Ward/Bed No First Floor, SICU,
Bed no:SICU 6

Primary Consultant Dr. SURESH GOUD
S(MS,M.Ch
Urology(SVIMS),Consultant
Urologist)--UROLOGY

Consultants

Surgeons Dr. SURESH GOUD
S(MS,M.Ch
Urology(SVIMS),Consultant
Urologist)--UROLOGY

Anesthesiologists Dr Subba Reddy
Kuppannagari--
ANAESTHESIOLOGY

☐ **Diagnosis**

Diagnosis

[Add
Diagnosis](#)

ARHIP56951

ARH1.0001233533

☐ **Surgery / Procedures
Done**

Surgery / Procedure

Surgery / Procedure Name	Start Date	End Date	Surgeons	Anesthetists
URETHRAL DILATATION PLUS BILATERAL NEPHROSTOMY PLUS EXTERNAL SPHINTUROTOMY,BLADDER NECK INCISION,Right DJ STENTING,SUPRA PUBIC CATHETER(SPC)(OPEN)				

OBSTRUCTIVE NEPHROPATHY WITH BILATERAL HYDRONEPHROSIS
UROSEPSIS
BILATERAL URETERIC STRICTURE

THIMBLE BLADDER
HIGH BLADDER NECK
STRICTURE URETHRA
NEUROGENIC BLADDER
BILATERAL PYELONEPHRITIS
RIGHT URETERIC CALCULI
CKD ACUTE AND CKD
RIGHT IJV IN SITU
SEVERE PAH, RV DILATED
SEVERE TR

SURGERIES:

RIGHT DJ STENTING,
URETHRAL DILATATION,
BNI,
B/L NEPHROSTOMY,
OPEN SPC

C/o burning micturition since 7 days

K/c/o CKD on MHD

AT ADMISSION:

Afebrile

PR: 119/min

BP: 130/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft

A 73 years old male patient Mr. MALLAIAH KYATHAM came with c/o burning micturition since 7 days. K/c/o CKD on MHD. All necessary investigations were done and diagnosed as OBSTRUCTIVE NEPHROPATHY WITH BILATERAL HYDRONEPHROSIS, UROSEPSIS, BILATERAL URETERIC STRICTURE, THIMBLE BLADDER, HIGH BLADDER NECK, STRICTURE URETHRA, NEUROGENIC BLADDER, BILATERAL PYELONEPHRITIS, RIGHT URETERIC CALCULI, CKD ACUTE AND CKD, RIGHT IJV IN SITU, SEVERE PAH, RV DILATED, SEVERE TR. SURGERY: RIGHT DJ STENTING, URETHRAL DILATATION, BNI, B/L NEPHROSTOMY, OPEN SPC. Patient is wanted to discharged on LAMA, risk explained to patient attender, but they insisting for LAMA.

ARH1.0001234188		Name	Mr. RAJA MALLAIAH PABBA
Patient Identifier	ARHIP56966	Age	84Yr 0Mth 5Days
Sex	Male	Date of Admission	04-Aug-2022
Date of Discharge			
MLC No			
Address	7-2-150, MANKAMMATHOTA,,Karimnagar,Telangana	Ward/Bed No	First Floor, SICU, Bed no:SICU 4
Primary Consultant	Dr. GOUTHAM ROY (MS)(General		

? PSUEDO OBSTRCTION
WITH UNCONTROLLED HTN WITH SEPSIS

c/o multiple episodes of loose stools, multiple episodes of vomitings, abdominal distention

PHYSICAL EXAMINATION:

ON ADMISSION

Pt c/c/c

afebrile

PR-98/min

BP-170/90mmhg

RR-19/min

RS-BAE+

CVS-S1S2+

CNS-NAD.

SPO2-98%

A 84yr old male patient Mr. RAJA MALLAIAH PABBA came with c/o multiple episodes of loose stools, multiple episodes of vomitings, abdominal distention. All necessary investigations done and diagnosed as **INTESTINAL OBSTRUCTION**, patient Planned for exploratory laparotomy, resection and anastomosis. But the patient is unwilling. So patient is being discharged at request.

DISCHARGE MEDICATION:

1. TAB: OFLOX-OZ TWICE DAILY AT 8AM, 8PM FOR 7 DAYS.
2. TAB: SOMPRAZ-L TWICE DAILY AT 8AM, 8PM FOR 15 DAYS.
3. TAB: VSL-3 ONCE DAILY AT 2PM FOR 15 DAYS.
4. TAB: DOLO 650 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.
5. SYP: SUCRAFIL-O 2tsp THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 15 DAYS.
6. SYP: LACTIFIBER 3tsp ONCE DAILY AT 8PM FOR 15 DAYS.
7. TAB: ND Q10 ONCE DAILY AT 2PM FOR 15 DAYS
8. GLUTAVALT SACHETS ONCE DAILY AT 2PM FOR 15 DAYS.
9. PERIPHERAL TPN @ 50 ml/hr
10. TAB: AMLODAC 5 MG ONCE DAILY AT 9AM TO CONTINUE.

Review after 7 days in General Surgery OPD.

ARH1.0001234324		Name	Mrs. KARUNA SARKAR
Patient Identifier	ARHIP57016	Age	54Yr 0Mth 1Days
Sex	Female	Date of Admission	08-Aug-2022
Date of Discharge			
MLC No			
Address	EASGAON, VILLAGE NO:2, NASRUM NAGAR, SIRPUR KAGAZNAGAR,Sirpur (T),Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU13
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

HAEMODYNAMICALLY UNSTABLE VT
 PHARMACOLOGICAL CARDIOVERSION DONE WITH AMIODARONE
 CAD -S/P PTCA (07/22)
 R/F: DM

Complaint of palpitations, vomiting and shortness of breath.

AT ADMISSION:

Afebrile

PR: 96/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft, BS+

A 54-year-old female patient Mrs. KARUNA SARKAR presented with complaint of palpitations, vomiting and shortness of breath. Patient had VT, haemodynamically unstable, treatment taken outside and referred here for further management. On evaluation patient diagnosed to have CAD -S/P PTCA done 1 month back. Patient was started with INJ. NORADRENALINE and INJ. Cordarone. Patient reverted to sinus rhythm. Patient is discharged at request and referred to Electrophysiologist for further management.

Treatment given

INJ CORDARONE
INJ NORADRENALINE
INJ PAN
INJ PERINORM
INJ ZOSTUM
INJ HUMAN INSULATARD
INJ HUMAN ACTRAPID
TAB ECOSPRIN 75 mg
TAB BILINTA
TAB ATORVA

ARH1.0001234193		Name	Mrs. ANASURYA MUNIKOTA
Patient Identifier	ARHIP56961	Age	75Yr 0Mth 5Days
Sex	Female	Date of Admission	04-Aug-2022
Date of Discharge			
MLC No			
Address	H.NO:3- 25,KALIKOTA,KATHALAPUR,JAGITIAL,Other,Oth er	Ward/ Bed No	First Floor, CICU , Bed no:CICU1 2
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

COMPLETE HEART BLOCK
 NORMAL LV FUNCTION,
 TPI DONE ON 04/08/2022
 CORONARY ANGIOGRAM DONE ON 04/08/2022 - NORMAL CORONARIES

PPI DONE ON 06/08/2022 (MODEL, VITATRON Q20A2, SR 540028797)

R/F: HTN

C/o giddiness, sudden syncope, fever since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 36/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 96%

P/A: Soft

A 75 years old female patient Mrs. ANASURYA MUNIKOTA came with C/o giddiness, sudden syncope, fever since 1 day. All necessary investigations were done and diagnosed as COMPLETE HEART BLOCK
NORMAL LV FUNCTION, TPI DONE ON 04/08/2022, CORONARY ANGIOGRAM DONE ON 04/08/2022 – NORMAL CORONARIES, PPI DONE ON 06/08/2022 (MODEL, VITATRON Q20A2, SR 540028797). Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. AUGMENTIN DUO 625 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 7 DAYS
- 2) TAB. RANTAC 150 MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 10 DAYS.
- 3) TAB. DOLO 650MG THRICE IN A DAY AT 8 AM 2 PM 8 PM FOR 5 DAYS.
- 4) T-BACT OINTMENT FOR L/A

REVIEW AFTER 10 DAYS TO CARDIAC OPD

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER / EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL CENTER AT- 0878-2200000.

OBSTRUCTIVE NEPHROPATHY WITH BILATERAL HYDRONEPHROSIS
UROSEPSIS
BILATERAL URETERIC STRICTURE
THIMBLE BLADDER
HIGH BLADDER NECK
STRICTURE URETHRA
NEUROGENIC BLADDER
BILATERAL PYELONEPHRITIS
RIGHT URETERIC CALCULI
CKD ACUTE AND CKD
RIGHT IJV IN SITU
SEVERE PAH, RV DILATED
SEVERE TR

RIGHT DJ STENTING
URETHRAL DILATATION
DNI NASELIN BILATERAL NEPHROSTOMY
OPEN SPC

Patient is wanted to discharged on LAMA, risk a splendid to patient attender, but they insisting for LAMA

ARH1.0001234236		Name	Mr. HARI KISHAN LAHOTI
Patient Identifier	ARHIP56984	Age	63Yr 0Mth 3Days
Sex	Male	Date of Admission	06-Aug-2022
Date of Discharge			
MLC No			
Address	BELLAMPALLY,Telangana	Ward/ Bed No	First Floor, CICU , Bed no:CICU 9
Primary Consultant	Dr. Vidya Sagar A--CARDIOLOGY		

CAD - AWMi, SR, SEVERE LV DYSFUNCTION
CORONARY ANGIOGRAM DONE ON 06/08/2022 - CAD-SVD (LAD)

PTCA+DES TO LAD WITH 3.0 X 48 MM XIENCE XPEDITION DONE ON 06/08/2022
R/F: DM, TOBACCO CHEWING

C/o Retrosternal chest pain since 1 day

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/60mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 97%

P/A: Soft

A 63years old male patient Mr. HARI KISHAN LAHOTI came with c/o retrosternal chest pain since 1 day. All necessary investigations were done and diagnosed as CAD - AWTMI, SR, SEVERE LV DYSFUNCTION
CORONARY ANGIOGRAM DONE ON 06/08/2022 - CAD-SVD (LAD), PTCA+DES TO LAD WITH 3.0 X 48 MM XIENCE XPEDITION DONE ON 06/08/2022. Post procedure is uneventful. Patient is being discharged in hemodynamically stable condition with required medication and advice.

DISCHARGE MEDICATION:

- 1) TAB. DISPRIN 325 MG THRICE IN A DAY AT 8 AM 2 PM 8 PM TO CONTINUE.
- 2) TAB. BRILINTA 90MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 3) TAB. NOVASTAT 40MG ONCE DAILY AT 2PM TO CONTINUE.
- 4) TAB. BETALOC 25MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 5) TAB. RAMISTAR 2.5MG **TWICE IN A DAY AT 8 AM 8 PM** TO CONTINUE.
- 6) TAB. OXRA 10MG ONCE DAILY AT 8PM TO CONTINUE.
- 7) SYP. POTKLOR 15 ML THRICE IN A DAY AT 8 AM 2 PM 8 PM
- 8) TAB. VELOZ 20 MG ONCE DAILY AT 8AM TO CONTINUE.
- 9) SYP. CREMAFFIN 10 ML ONCE DAILY AT 8PM

REVIEW AFTER 10 DAYS TO CARDIAC OPD WITH FBS, PLBS REPORTS

DO NOT STOP ANY MEDICATIONS WITHOUT CONSULTING THE PRIMARY CONSULTANT.

EXPLAINED REGARDING 5% RISK OF STENT THROMBOSIS / INSTENT RESTENOSIS /HEART FAILURE.

EXPLAINED REGARDING 5% CHANCE OF REDO PTCA/ CABG.

--> PLEASE CALL EMERGENCY SERVICES AT 0878-2200000 AND ASK FOR YOUR DOCTOR /ER /
EXTENSION NUMBER, IN CASE OF FOLLOWING SYMPTOMS.

SEVERE PAIN AT THE OPERATED SITE.

DISCOLORATION AND SWELLING OF THE OPERATED SITE.

BLEEDING FROM THE OPERATED SITE.

CHEST PAIN.

ACUTE SHORTNESS OF BREATH.

ALTERED LEVEL OF CONSCIOUSNESS.

LOW URINE OUTPUT IN LAST 24 HOURS.

FEVER ABOVE (101°F).

NEW ONSET OF PAIN AND WORSENING OF EXISTING PAIN.

WORSENING OF ANY OF YOUR SYMPTOMS

ANY OTHER SIGNIFICANT COMPLAINTS.

---> IN CASE YOU DO NOT UNDERSTAND YOUR DISCHARGE MEDICATIONS AND / OR NOTICE ANY NEW
REACTION TO YOUR MEDICATIONS, PLEASE CALL 9963145554.

---> FOR YOUR APPOINTMENTS, SCHEDULED OR OTHERWISE, PLEASE REACH OUT TO OUR CALL
CENTER AT- 0878-2200000.

ARH1.0001115075

Name

Mr. P NARSAIAH

Patient Identifier

ARHIP57005

Age

58Yr
10Mth
10Days

Sex

Male

Date of Admission

07-Aug-2022

**Date of Discharge
MLC No**

Address

8-4-371,GANESH
NAGAR,Karimnagar,Telangana

**Ward/
Bed No**

Second
Floor,
Semi
Private
, Bed
no:118
A

Primary Consultant

Dr. Vidya Sagar A--CARDIOLOGY

UNSTABLE ANGINA, SR

NORMAL LV FUNCTION

CORONARY ANGIOGRAM (09/08/2022) -CAD-LAD mild disease

PLAN MEDICAL MANAGEMENT

R/F : HTN

C/o chest pain since 1 day

AT ADMISSION:

Pt conscious, coherent

Afebrile

PR: 82/min

BP: 120/80mmHg

RS: BAE+

CVS: S1S2

RR: 18/min

SPO2: 99%

P/A: Soft

A 58 years old male patient NARSAIAH came with c/o chest pain since 1 day. All necessary investigations were done and diagnosed as UNSTABLE ANGINA, SR, NORMAL LV FUNCTION, CORONARY ANGIOGRAM (09/08/2022) -CAD-LAD mild disease, PLAN MEDICAL MANAGEMENT. Patient is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. TAB. CLOPILET 75MG ONCE DAILY AT 2PM TO CONTINUE.
2. TAB. ATORVA 40MG ONCE DAILY AT 2PM TO CONTINUE.
3. TAB. ESPIN-AT ONCE DAILY AT 2PM TO CONTINUE.
4. TAB. RANTAC 150MG **TWICE IN A DAY AT 8 AM 8 PM** FOR 11 DAYS

REVIEW AFTER 11 DAYS TO CARDIAC OPD

ARH1.0001231589		Name	Mr. RAMANAIAH BOGA
Patient Identifier	ARHIP56794	Age	67Yr 1Mth 30Days
Sex	Male	Date of Admission	25-Jul-2022
Expired Date	31-Jul-2022		
MLC No			
Address	BEGUMPET, RAMAGIRI, PEDDAPLLI, Other, Telangana	Ward/Bed No	First Floor, MICU, Bed no: MIC U 3
Primary Consultant	Dr. RAMCHANDER TORREM(DM(NEPHROLOGY) (NIMS), RENAL TRANSPLANT PHYSICIAN)-- NEPHROLOGY	Consultants	
Surgeons		Anesthesiologists	

Diagnosis

Diagnosis

Disease	Disease Type
ASPIRATION PNEUMONIA ACUTE CKD AND CAD.	

C/o fatigue since 1 day

K/c/o CKD, CAD, Hypothyroidism

ADMISSION VITALS:

PR-86/min

BP-130/90mmhg

RR-22/mmin

RS-BAE+

CVS-S1S2+

P/A-soft

A 67years old male patient RAMANAIAH presented to ER with c/o fatigue since 1 day. All necessary investigations were done and diagnosed as ASPIRATION PNEUMONIA ACUTE CKD AND CAD . Patient was intubated in view low saturation. Patient had sudden cardiac arrest on 31/07/2022 at 8.00 AM, immediately CPR was initiated as per ACLS protocols, but patient not reverted to normal Sinus Rhythm. Pupils dilated and fixed, Carotid pulse not felt. 12 lead ECG showed asystole, hence declared dead at 8.28 AM on 31/07/2022.

CAUSE OF DEATH :

CARDIOPULMONARY ARREST SECONADRY TO ASPIRATION PNEUMONIA ACUTE CKD AND CAD

APJ1.0002524070

Patient Identifier

ARHIP56957

Name

Mr. PRAKASH LAL
NANKANI

Age

75Yr 7Mth
24Days

Sex Male
Date of Discharge 04-Aug-2022
MLC No

Address HYDERABAD,Hyderabad,Telangana

Primary Consultant DR. SANJAY KUMAR
KAMINWAR(MD,DM(Neurology),Consultant Neuro Physician)--NEUROLOGY
Surgeons

Date of Admission 04-Aug-2022

Ward/Bed No Ground Floor, Emergency Ward, Bed no:EME6

Consultants

Anesthesiologists

Diagnosis

Diagnosis

Disease	Disease Type
.	

SEIZURS SYNCOPE

C/o sudden fall at bathroom associated with giddiness
Tongue bite+
K/c/o HTN

AT ADMISSION:

Afebrile

PR: 63/min

BP: 100/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 75 years old male patient Mr. PRAKASH LAL NANKANI came with c/o sudden fall at bathroom associated with giddiness, tongue bite+ . All necessary investigations were done and diagnosed as SEIZURS SYNCOPÉ. Managed conservatively. Patient attendants requested for discharge, hence patient is being discharged under LAMA.

ARH1.0001002916

Name

Mrs. BHARATHA
LAXMI T

**Patient
Identifier**

ARHIP56986

Age

66Yr
5Mth
19Days

Sex

Female

**Date of
Admission**

06-Aug-
2022

**Date of
Discharge
MLC No**

Address

1-4-71, NEAR BHARATH
THEATRE,Karimnagar,Andhra Pradesh

**Ward/
Bed No**

First
Floor,
MICU,
Bed
no:MIC
U 3

**Primary
Consultant**

Dr Chandra Shekar Sathineni

S

DKA
METABOLIC ENCEPHALOPATHY

C/o altered sensorium since 1 day
Known case of hypertension, diabetic mellitus

AT ADMISSION:

Afebrile

PR: 98/min

BP: 110/70mmHg

RS: BAE+

CVS: S1S2

RR: 20/min

SPO2: 98%

P/A: Soft,

A 66 years old female patient Mrs. BHARATHA LAXMI T came with c/o altered sensorium since 1 day. Known case of hypertension, diabetic mellitus. All necessary investigations were done and diagnosed as DKA, METABOLIC ENCEPHALOPATHY. Managed conservatively. Patient condition improved and is being discharged in hemodynamically stable condition with required medication and advise.

DISCHARGE MEDICATION:

1. INJ TOUJEO 25 UNITS ONCE IN A DAY AT 10 PM.
2. INJ APIDRA 15 UNITS AT 8AM, 15 UNITS AT 2PM & 10 UNITS AT 8PM.
3. TAB. ARVAST CV ONCE DAILY AT 8PM FOR 10 DAYS
4. TAB. TAZOLAC CT ONCE DAILY AT 2PM FOR 10 DAYS
5. GLUTARISE SACHETS ONCE DAILY AT 2PM FOR 10 DAYS

REVIEW AFTER 7 DAYS IN GENERAL MEDICINE OPD

MODS

History of vomiting, loose motions and shortness of breath since 1 day

Cardiologist consultation taken and Nephrologist consultation taken and advice followed

The patient was intubated on 05/02/22 at 1 p.m. and connected to mechanical ventilator
6 haemodialysis sheath placed on 03/08/22